

**HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS  
WELFARE FUND**

**RESTATED AND EFFECTIVE  
JANUARY 1, 2008**

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## **ARTICLE 1 – PURPOSE**

These Rules and Regulations are adopted by the Trustees of the Midwest Operating Engineers Welfare Fund under the terms of the Agreement and Declaration of Trust in order to establish provisions which determine the eligibility of employees for the benefits provided by the Midwest Operating Engineers Welfare Fund and to prescribe the amount, extent, conditions and methods of payment under the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund.

The Plan provides comprehensive health benefits intended to help Participants stay healthy and provides financial protection against catastrophic health care costs. However, not all types of treatment are covered.

The Plan provides Retiree Benefits for certain eligible retired employees. Qualifying retired employees may elect to continue coverage for themselves and their eligible Dependents by applying and making self-payments within the specified timeframes, as set forth in Article 17.

## ARTICLE 2 – DEFINITIONS

Words and phrases appearing in this Plan shall have the respective meanings set forth in this Article, unless the context clearly indicates to the contrary.

### **Section 1. Administrative Manager.**

The person, firm or corporation employed by the Trustees, charged with the recordkeeping, reporting and disclosure, processing of applications for benefits and related functions attendant to the administration of the Plan. (The business office of the Administrative Manager is referred to herein as the “Fund Office.”)

### **Section 2. Ambulatory Care Facility.**

Any institution, place or building, licensed by the state in which the facility is located, devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures or any facility in which a medical or surgical procedure is used to terminate a Pregnancy, irrespective of whether the facility is devoted primarily to this purpose. Such facility shall not provide beds or other accommodations for the overnight stay of patients.

The term Ambulatory Care Facility does not include:

- (a) any institution, place, building or agency required to be licensed pursuant to the hospital licensing act of any state;
- (b) any person or institution providing maintenance, care or nursing of persons who are ill, aged or physically infirm;
- (c) Hospitals or ambulatory care facilities maintained by any state or any department or agency thereof, where such department or agency has authority under law to establish and enforce standards for hospitals or Ambulatory Care Facility under its management and control;
- (d) Hospitals or ambulatory care facilities maintained by the federal government or agencies thereof; or
- (e) any place, agency, clinic or practice, public or private, whether organized for profit or not, devoted exclusively to the performance of dental or oral surgical procedures.

**Section 3. Association.**

Employer associations that are, or may hereafter become, parties to a collective bargaining agreement with the Union, as the representatives of Employers, bound thereby to make contributions to the Fund.

**Section 4. Benefit Plan.**

The Plan provides several benefit levels, which are referred to herein as Benefit Plans A, B, C, D, E and F. The Benefit Plan for which an Employee and his Dependents are eligible is determined by the collective bargaining agreement or participation agreement between the Employee's Contributing Employer and the Trustees. If an Eligible Employee has one or more Dependents, such Dependents shall be eligible for the same Benefit Plan for which the Employee is eligible.

**Section 5. Brand Name Drug.**

A Prescription Drug which is under patent protection.

**Section 6. Break in Coverage.**

A period of 63 days or more between the date a person's Creditable Coverage ended and the date the person becomes covered under this Plan.

**Section 7. Calendar Year.**

The period of twelve months starting on January 1 of each year.

**Section 8. Case Manager.**

A utilization management company operating under a contract with the Plan that determines, subject to the final decision of the Trustees, what services and supplies are Medically Necessary, and the appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include, but is not limited to:

- (a) pre-certification and/or pre-authorization;
- (b) concurrent and/or continued stay review;
- (c) discharge planning;
- (d) retrospective review;

- (e) case management;
- (f) Hospital, Physician or other Health Care Provider bill audits; and
- (g) provider fee negotiation.

**Section 9. Continuing Care.**

Care provided on an ongoing basis to support those persons who are suffering from a chronic and/or incapacitating illness, thus making them unable to cope unassisted with daily living. Continuing Care is available in the home, domiciliary homes, inpatient health facilities, nursing homes, geriatric day care centers, as well as any setting deemed appropriate by the medical profession.

Continuing Care includes, but is not limited to, ventilator care, parenteral therapy, indecision as to post-acute hospital plans, medication monitoring, renal dialysis, any life sustaining treatment, procedure or intervention that would not be effective to remove the qualifying condition, would be futile or would serve only to prolong the dying process.

**Section 10. Contributing Employer.**

A Contributing Employer is any of the following:

- (a) an individual, partnership or similar business entity, firm or corporation, which is an Employer under ERISA that is bound to make contributions to the Fund, under the provisions of a written:
  - (i) collective bargaining agreement entered into with the Union by an Association on behalf of its members, or as the collective bargaining representative of such individual, partnership or similar business entity, firm or corporation on behalf of employees within the bargaining unit covered by such collective bargaining agreement; or
  - (ii) collective bargaining agreement entered into separately with the Union on behalf of employees within the bargaining unit covered by such collective bargaining agreement; or
  - (iii) participation agreement entered into with the Board of Trustees, at their discretion;
- (b) an Association, which enters into a written agreement with the Union, whereunder it is bound to make employer contributions to the Fund on behalf of its employees included within the definition of Employee.

- (c) the Trustees of any of the following:
  - (i) the Midwest Operating Engineers Pension Fund;
  - (ii) the Midwest Operating Engineers Welfare Fund;
  - (iii) the Operating Engineers Local 150 Apprenticeship Fund;
  - (iv) the Local 150, I.U.O.E. Vacation Savings Plan;
  - (v) the Midwest Operating Engineers Construction Industry Research Service Trust Fund; and
  - (vi) the Midwest Operating Engineers Information Technology Services Corporation.

who enter into a written agreement with the Union whereunder they are bound to make contributions to the Fund on behalf of their employees within the definition of an Employee; or

- (d) the Union, upon its written declaration delivered to the Trustees, whereunder the Union is bound to make contributions to the Fund on behalf of its employees within the definition of an Employee.

**Section 11. Co-Pay.**

That portion of the Covered Expense, which is required to be paid by the Participant and is not subject to reimbursement by the Plan.

**Section 12. Cosmetic Surgery or Treatment.**

Surgery or treatment which is performed primarily to change the appearance or improve the self-esteem of a person rather than to enhance the function or usefulness of a part of the body.

**Section 13. Covered Expense.**

- (a) With respect to all Plan benefits:
  - (i) a Covered Expense will not exceed the Reasonable and Customary Charge, as determined by the Administrative Manager; and
  - (ii) an expense must also be allowable and not excluded from coverage under the benefit provisions of the Plan in order to be considered a Covered Expense.

- (b) With respect to the Comprehensive Medical Expense Benefit, the charges for reasonably necessary services and supplies for the diagnosis or care of a Participant's Illness or Injury. To be reasonably necessary, the service or supply must be ordered by a Physician and must be recognized throughout the health care profession as the customary treatment for the Illness or Injury.

**Section 14. Creditable Coverage.**

Coverage of an individual under any of the following forms of health insurance:

- (a) a group health plan;
- (b) health insurance coverage;
- (c) Part A, Part B, or Part C of Title XVIII of the Social Security Act (Medicare);
- (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under SSA §1928 (relating to childhood immunizations);
- (e) Chapter 55 of Title 10, United States Code (CHAMPUS/TRICARE);
- (f) a medical care program of the Indian Health Service or of a tribal organization;
- (g) a state health benefits risk pool;
- (h) a health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Plan);
- (i) a public health plan (as defined in applicable regulations); or
- (j) a health benefit plan under Section 5(e) of the Peace Corps Act (22 USCS §2504(e)).

**Section 15. Custodial Care.**

- (a) Services and supplies that meet one of the following conditions:
  - (i) Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.

- (ii) Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.
- (b) Care that meets one of the conditions above is Custodial Care regardless of any of the following:
  - (i) who recommends, provides or directs the care;
  - (ii) where the care is provided; or
  - (iii) whether or not the patient or another caregiver can be or is being trained to care for himself or herself.

**Section 16. Dental Services.**

Any service involving teeth, tooth supporting structures, and tissues of the oral cavity.

**Section 17. Dentist.**

A person who is licensed to practice dentistry or perform oral surgery and who is practicing within the scope of his license. A licensed dentist will be considered a Dentist while practicing within the scope of his license, and to the extent that benefits are provided.

**Section 18. Eligible Dependent.**

Any or all of the following individuals:

- (a) the Eligible Employee's lawful spouse, other than a spouse separated by a decree of a court of competent jurisdiction;
- (b) those children of the Eligible Employee who are unmarried, who have not reached their 19th birthday, who live with the Employee for at least one-half of the calendar year, and who are dependent on the Employee for at least one-half of their support. "Support" means the furnishing of food, clothing, and a place to live, medical and dental care and education.

For this purpose, "children" shall include:

- (i) natural children;
- (ii) stepchildren. Stepchildren are the natural or adopted children of an Eligible Employee's Spouse.

*Section 18(b)  
amended effective  
January 1, 2011  
(see Amendment  
No. 9).*

- (iii) legally adopted children or those for whom adoption proceedings have been started and the children are placed in the Eligible Employee's home by a licensed placement agency for the purpose of adoption.
- (iv) children for whom the Plan is required by a Qualified Medical Child Support Order (QMCSO) to consider eligible dependents. The following procedures apply to QMCSOs:
  - (A) If a copy of a proposed Medical Child Support Order as defined in ERISA Section 609(a) is filed with the Administrative Manager, the Administrative Manager shall promptly notify the Eligible Employee and each alternate recipient of the receipt of such order and the Plan's procedures for determining whether the order is a Qualified Medical Child Support Order (QMCSO), as further defined in ERISA Section 609(a).
  - (B) The Administrative Manager shall then determine whether the order is a QMCSO pursuant to the Plan's procedures, and notify the Eligible Employee and each alternate recipient of the determination.
  - (C) The Plan shall provide benefits in accordance with the applicable requirements of any QMCSO. The QMCSO shall not require any type or form of benefit or any option not otherwise provided under this Plan.
  - (D) Any payment for 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 or the alternate recipient's custodial parent or legal guardian.

*Section 18(c)*  
*amended effective*  
*January 1, 2011*  
*(see Amendment*  
*No. 9).*

- (c) those children of the Eligible Employee who have reached their 19th birthday but are unmarried and incapable of self-sustaining employment by reason of mental retardation or physical handicap, provided:
  - (i) such incapacity commenced prior to the limiting age in subsection (b) above; and
  - (ii) such children are chiefly dependent upon the Eligible Employee for financial support and maintenance; and
  - (iii) the Eligible Employee submits satisfactory proof of such incapacity within 31 days after the upper age limit is reached. The Trustees may require, at reasonable intervals following the date the

dependent reaches the age limit, subsequent proof of continuing incapacity and dependency. The Trustees reserve the right to have such dependent examined by a Physician of their choice to determine the existence of such incapacity.

“Mental retardation” means significantly subaverage, general intellectual functioning which exists concurrently with impairment in adaptive behavior.

- (d) (i) full-time students, who were Eligible Dependents at the time they reached their 19th birthday, provided that they:
  - (A) have remained continuously eligible under the Plan;
  - (B) have not reached their 23rd birthday; and
  - (C) are dependent on the Employee for at least one-half of their support.
- (ii) Proof of full-time student status must be provided to the Administrative Manager every semester. The Trustees require documentation from the school registrar’s office, which must bear the school seal.
- (iii) Eligibility ends on the last day of the Benefit Quarter (if eligibility is based on Contribution Quarters) or Month (if eligibility is determined on a Month-to-Month basis) in which the Dependent is last enrolled as a full-time student. However, a Dependent who is enrolled during a spring semester will remain continuously eligible between semesters if subsequently enrolled in the next fall semester. A Dependent child who no longer is a full-time student or otherwise no longer meets the Plan’s definition of Dependent, as set forth in this Section 18, may elect COBRA Coverage as set forth in Article 3. A Dependent child who stops being continuously eligible because he is no longer a full-time student and who did not elect COBRA Coverage who subsequently re-enrolls as a full-time student must elect to make COBRA payments for the period of time he was not a full-time student to again be eligible under the Plan. Only one such exception to the requirement of maintaining continuous eligibility will be allowed during the Dependent’s lifetime. The COBRA payment amount will be an amount equal to the then current monthly COBRA self-payment rate times the number of Months he was not eligible. The Dependent must provide written notice to the Fund Office of his election and make full payment within 30 days.

*Section 18(d)  
amended effective  
January 1, 2011  
(see Amendment  
No. 9).*

*Section 18(d) amended  
by the addition of sub-  
paragraph (iv) effective  
January 1, 2010 (see  
Amendment No. 9.)*

**Section 19. Eligible Employee.**

An individual who satisfies the conditions for eligibility under Article 3.

**Section 20. Employee.**

An Employee is any of the following:

**(a) Bargaining Unit Employee**

- (i) a person who is a member of the bargaining unit and who is actively employed by a Contributing Employer on whose behalf payments are required to be made to the Fund; or
- (ii) a person employed by a Contributing Employer as a “Supervisor” as such term is defined in the Labor Management Relations Act of 1947, as amended and covered under the applicable collective bargaining agreement.

**(b) Non-Bargaining Unit Employee**

A person who is not a member of the bargaining unit but who is permitted to participate in this Plan under the terms of a participation agreement between the Trustees and the Employee’s Contributing Employer who is party to a collective bargaining agreement with the Union.

**(c) Staff Employee**

A person employed by and under the direction and control of any of the following:

- (A) the Union;
- (B) an Association;
- (C) the Trustees of the Midwest Operating Engineers Pension Fund;
- (D) the Trustees of the Midwest Operating Engineers Welfare Fund;
- (E) the Trustees of the Operating Engineers Local 150 Apprenticeship Fund;
- (F) the Trustees of Local 150, I.U.O.E., Vacation Savings Plan;
- (G) the Trustees of the Midwest Operating Engineers Construction Industry Research Service Trust Fund; or

(H) the Midwest Operating Engineers Information Technology Services Corporation;

on whose behalf such Employer is obligated to make contributions to the Fund.

**Section 21. ERISA.**

The Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to any section or subsection of ERISA includes reference to any comparable or succeeding provisions of any legislation, which amends, supplements or replaces such section or subsection.

**Section 22. Experimental or Investigative Services.**

A drug, device, medical treatment or procedure is considered an experimental or investigative service:

- (a) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (b) 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, or if federal law requires such review or approval; or
- (c) if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (d) if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its 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 pro-

cedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

**Section 23. Fund.**

The Midwest Operating Engineers Welfare Fund, established to receive and invest contributions of the Contributing Employers and from which benefits are paid.

**Section 24. Generic Drug.**

A Prescription Drug which is a multi-source drug of a branded medication which is off patent.

**Section 25. Health Care Provider.**

Any of the following institutions or persons for whom benefits may be paid for services provided within the scope of each practitioner's specialty and license and only within the provisions and limitations of the Plan. Such practitioners and institutions include:

- (a) Doctors of Medicine (MD);
- (b) Doctors of Osteopathy (DO);
- (c) Doctors of Podiatry or Chiropody (DPM or DSC);
- (d) Doctors of Chiropractic (DC);
- (e) Doctors of Medical Dentistry (DMD); or
- (f) Optometrists (OD);
- (g) Doctors of Dental Surgery (DDS);
- (h) Physical Therapists (PT, LPT);
- (i) Physical Therapy Assistants (PTA) who are providing the services under the direct supervisions of a PT and whose services are billed by the PT;
- (j) Occupational Therapists (OT);

- (k) Occupational Therapy Assistants (OTA) who are providing the services under the direct supervisions of an OT and whose services are billed by the OT;
- (l) Physicians Assistants (PA, PA-C, etc.) when the services are billed by a Hospital or Physician;
- (m) Surgical Assistants (SA, CSA, etc.) when the services would be covered had they been performed by a Physician.
- (n) Registered nurses (RN) and advanced nurse practitioners (APN, NP, etc.). The maximum allowable charge for a service performed by a nurse practitioner will be 85% of the allowable expense for an M.D. or D.O. for the same service;
- (o) Speech Therapists (ST, LST);
- (p) Certified Registered Nurse Anesthetists (CRNA);
- (q) Hospitals;
- (r) Skilled Nursing Facilities;
- (s) Hospices;
- (t) Laboratories;
- (u) MRI Centers;
- (v) Home Health Care Agencies;
- (w) Licensed Ambulatory Care Facilities; and
- (x) Licensed ambulance services.

*Section 25(m) amended effective January 1, 2009 (see Amendment No. 10.)*

*Section 25 amended by the addition of subparagraph (y) effective January 1, 2009 (see Amendment No. 3).*

**Section 26. Home Health Care.**

- (a) Home Health Care is a program of continued medical care and treatment rendered by a licensed Home Health Care Agency team at home in lieu of a Hospital confinement or a stay in a Skilled Nursing Facility. Also, it must be for the care or treatment of sick or injured persons and must be ordered in writing by the eligible person's Physician; the Physician must certify, in writing, that without Home Health Care, confinement in a Hospital or Skilled Nursing Facility would be required.

- (b) Pre-certification is required before benefits will be payable for Home Health Care.
- (c) Home Health Care consists of these services and supplies:
  - (i) part-time intermittent home nursing care from or supervised by a Registered Nurse;
  - (ii) part-time or intermittent home health aid services;
  - (iii) physical therapy, occupational therapy, and speech therapy; and
  - (iv) medical supplies, drugs and medications prescribed by a Physician, and laboratory services, but only to the extent that they would have been covered in a Hospital or Skilled Nursing Facility.
- (d) Home Health Care does not include:
  - (i) full-time nursing care at home;
  - (ii) private duty nursing;
  - (iii) meals delivered to the home; or
  - (iv) homemaker services.

**Section 27. Home Health Care Agency.**

A Home Health Care Agency is a public agency or private organization that is licensed as a Home Health Care Agency by the State and is certified as such under Title XVIII of the Social Security Act that:

- (a) specializes in providing nursing and other therapeutic services in the home;
- (b) operates within the scope of its license; and
- (c) maintains the required documentation and will furnish said documentation upon written request.

**Section 28. Hospice.**

An agency which:

- (a) provides inpatient or outpatient Hospice Care, meaning a coordinated program of home and inpatient care for the special physical, psychological and social needs of terminally ill persons and their families. A ter-

minally ill person is one who has been diagnosed by a Physician as having a life expectancy of six months or less;

- (b) is licensed as such and operating within the scope of the license;
- (c) maintains medical records on each patient and provides an ongoing quality assurance program;
- (d) has full-time supervision by at least one Physician; and
- (e) provides 24-hour nursing service by registered nurse.

**Section 29. Hospital.**

- (a) A Hospital is an institution which meets all of the following requirements:
  - (i) it is mainly engaged in providing inpatient medical care for diagnosis and treatment of an Injury or Illness, and routinely makes a charge for such care;
  - (ii) it is supervised by a staff of Physicians on the premises;
  - (iii) it provides on the premises 24 hour nursing services by registered nurses; and
  - (iv) it is operated with organized facilities for operative surgery on the premises, except for the following institutions:
    - (A) mental/psychiatric hospitals;
    - (B) drug/alcohol rehabilitation hospitals; and
    - (C) physical rehabilitation hospitals.
- (b) A Hospital does not include any institution:
  - (i) which is run mainly as a rest, nursing, or convalescent home;
  - (ii) for which any part is mainly for the care of the aged; or
  - (iii) which is engaged in the schooling of its patients.

**Section 30. Illness.**

- (a) A person's condition when the body's organs do not function normally; or

- (b) when a temporary ailment reduces the body's ability to function normally; or
- (c) Pregnancy.

**Section 31. Infertility.**

- (a) The inability to conceive; or
- (b) the inability to sustain a successful Pregnancy.

**Section 32. Injury.**

Bodily harm resulting from an accident. "Accident," as used in the foregoing, means an undesirable or unfortunate happening, unintentionally caused, resulting in harm.

**Section 33. Medically Necessary.**

Services and supplies that a Physician, exercising prudent clinical judgement, would provide to the patient for the purpose of evaluating, diagnosing or treating an Illness or Injury or its symptoms, and:

- (a) have been established as safe and effective by the American Medical Association or appropriate governing body;
- (b) are furnished in accordance with generally accepted professional medical standards for treatment of Illness or Injury;
- (c) are consistent with the signs, symptoms or diagnosis and treatment of an Illness or Injury;
- (d) are not primarily for the convenience of the eligible person or his doctor;
- (e) are the most appropriate supply or level of service which can be safely provided;
- (f) are necessary and appropriate treatment of the Illness or Injury;
- (g) are not Experimental or Investigative in nature; and
- (h) are not cosmetic in nature; that is, the treatment restores or repairs function.

The fact that a Physician or other Health Care Provider deems a service to be medically necessary is not binding on the Trustees.

**Section 34. Medicare.**

The three health care programs, a hospital benefit plan (Part A), a supplementary medical benefits plan (Part B), and the health care plans under the Medicare + Choice program (Part C), as established by Title XVIII of the Social Security Act, as amended.

**Section 35. Medicare Part D.**

The prescription drug program provided under the Social Security Act for Medicare-eligible participants in accordance with Section 101 of Title I of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), as amended.

**Section 36. Mental or Nervous Disorder.**

A condition which is described and coded in the behavioral health section of the ICD-9 or DSM IV current edition of the Diagnostic and Statistical Manual of Mental Disorders.

**Section 37. Month.**

Any of the twelve calendar months of the year.

**Section 38. Municipal; Municipality.**

“Municipal” or “Municipality” means a city, village, town, county, township, school district, park district, sanitary district, or any other similar government district, or government division or subdivision, or cooperative government body or any “Public Employer” as defined in the Illinois Public Relations Act or an “Educational Employer” as defined in the Illinois Educational Labor Relations Act.

**Section 39. Owner/Relative.**

A corporate shareholder, officer and/or director, or a relative (as defined in the collective bargaining agreement) of a shareholder, officer and/or director for whom Contributions are required to be made to this Fund at the rate of 150 hours per month for twelve months per Calendar Year, irrespective of the amount of work they perform.

**Section 40. Participant.**

An Eligible Employee, Eligible Retiree or Eligible Dependent who is covered under the Plan according to the eligibility rules as set forth in Article 3 or Article 17.

**Section 41. Physician.**

A qualified doctor, physician or surgeon, who is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) and who is licensed to practice medicine and surgery in all of its branches.

**Section 42. Plan.**

The Health and Welfare Plan of the Midwest Operating Engineers, the Plan set forth herein, as amended from time to time.

**Section 43. Pre-Certification.**

A program designed to assure that certain health care services are Medically Necessary by having the Case Manager or Administrative Manager review the proposed treatment plan before the services are provided.

**Section 44. Preferred Provider Organization (PPO).**

A group or network of Hospitals, Physicians and Health Care Providers under contract with the Plan to provide health care services and supplies at agreed-upon discounted rates. Providers that participate in the Plan's PPO are referred to as "network providers" or "PPO providers," and when a Participant receives services from a network provider, his care is considered "in-network."

**Section 45. Pre-Existing Condition.**

A mental or physical condition for which medical advice, diagnosis, care or treatment was recommended or received during the applicable six-month Look-Back Period. Genetic information will not be considered a condition.

**(a) Look-Back Period**

The look-back period is the six-month period immediately before the Eligible Individual's Enrollment Date as defined below.

**(b) Enrollment Date**

- (i) An Employee's Enrollment Date is the date on which his coverage begins.
- (ii) The Employee's Enrollment Date is also the Enrollment Date for any individual who is a Dependent of the Employee on the Employee's Enrollment Date.
- (iii) The Enrollment Date for an individual who becomes a Dependent of the Employee after the Employee's Enrollment Date is the date the individual becomes the Employee's Dependent.

**Section 46. Pregnancy.**

A pregnancy or childbirth. The Plan considers Pregnancy to be an Illness for the purpose of benefit payments, except that the Plan's Pre-Existing Condition Limitation will not apply to Pregnancy.

**Section 47. Prescription Drugs.**

The following are considered Prescription Drugs provided they are prescribed and taken for a usage approved by the U.S. Federal and Drug Administration:

- (a) Federal Legend Drugs. (This is any medicinal substance which the federal Food, Drug and Cosmetic Act requires to be labeled "Caution - Federal Law prohibits dispensing without prescription.")
- (b) Drugs which require a prescription under state law but not under federal law.
- (c) Compound drugs. (This is a drug that has more than one ingredient. At least one of the ingredients has to be a federal Legend Drug or a drug, which requires a prescription under State law.)
- (d) Injectable insulin.

**Section 48. Prosthetics.**

A durable appliance or device which replaces a lost body part or function.

**Section 49. Reasonable and Customary Charge.**

- (a) With respect to a PPO provider, the Reasonable and Customary Charge means the charges set forth in the agreement between the PPO provider and the PPO or the Plan.
- (b) With respect to non-PPO providers, the charge for Medically Necessary services or supplies will be determined by the Administrative Manager or its designee to be the lowest of:
  - (i) the usual charge by the provider for the same or similar service or supply;
  - (ii) no more than the prevailing charge of 90% of the providers in the same or similar geographic area for the same or similar health care service or supply; or
  - (iii) the provider's actual charge.

The "prevailing charge" of most other providers in the same or similar geographic area for the same or similar health care service or supply shall be determined by the Administrative Manager who shall use proprietary data that is updated no less frequently than annually, and provided by a reputable company or entity.

**Section 50. Respite Care.**

A short-term inpatient stay, of up to five consecutive days, necessary to give temporary relief to the person who regularly assists with home care. Respite Care may also include short-term, in-home relief by a trained nurse for a family member who normally assists with home care.

**Section 51. Retiree; Eligible Retiree**

An Employee who has retired and who satisfies the eligibility requirements for Retiree Benefits set forth in Article 17.

**Section 52. Skilled Nursing Facility.**

A facility, which is operating legally to provide room and board for sick or injured persons under the supervision of a registered nurse or a Physician, and along with the services of nurses at all hours, meets all of the following tests:

- (a) it has available at all times the services of a Physician who is on the staff of a Hospital;

- (b) it keeps a daily medical record for each patient; and
- (c) it is not primarily a place for rest or custodial care, a place for the aged, a place for alcoholics or drug addicts, or a hotel.

**Section 53. Substance Abuse.**

The use of alcohol or other drugs to the extent that the person:

- (a) loses self-control;
- (b) places in peril his social, economic, psychological and physical welfare;  
or
- (c) could be a menace to public health, morals, safety or welfare.

**Section 54. Totally Disabled, Total Disability, Disability.**

A person is considered to be Disabled or Totally Disabled if it has been established to the satisfaction of the Trustees based upon competent medical evidence provided by a Physician that:

- (a) With respect to an Employee, the Employee is unable to perform any of the duties of his occupation or any occupation as a result of a non-Work-Related Illness or Injury, or, subject to the subrogation provisions of the Plan set forth in Article 16, a Work-Related Illness or Injury.
- (b) With respect to a Dependent, the Dependent is unable to perform the normal activities or duties of a person of the same age and sex as a result of a non-Work-Related Illness or Injury.

**Section 55. Trust Agreement.**

The Agreement and Declaration of Trust creating the Midwest Operating Engineers Welfare Fund dated May 31, 1953, as amended, supplemented and restated, and all amendments and modifications hereto, thereafter made.

**Section 56. Trustees.**

The persons selected under the Trust Agreement to administer the Plan and the Fund, together with their successors, sometimes collectively referred to as the "Board of Trustees" or the "Board."

**Section 57. Union.**

The International Union of Operating Engineers Local 150, and any other union whose collective bargaining agreement requires contributions to the Fund.

**Section 58. Work-Related Illness or Injury.**

Illness or Injury, which arises from or is sustained in the course of work for pay, profit or gain.

## ARTICLE 3 – ELIGIBILITY

### Section 1. General.

Employees shall become eligible for benefits if they perform covered work and sufficient contributions are made to the Fund on their behalf in accordance with the following provisions of this Article. In certain instances, eligibility may be based on self-contributions as specified in this Article.

### Section 2. Eligibility for Benefit Plan A.

#### (a) Quarterly Eligibility

##### (i) *Bargaining Unit Employees*

The benefits provided for individuals who meet the eligibility requirements in this Section 2(a)(i) are set forth in the Appendix on the Schedule of Benefits for Plan A-1.

##### (A) *Definitions*

- (1) “Benefit Quarter” means a period of three consecutive Months beginning January 1, April 1, July 1, October 1.
- (2) “Contribution Quarter” means a period of three consecutive Months beginning August 1, November 1, February 1, May 1.

##### (B) *Initial Eligibility*

An Employee shall become eligible for benefits on the first day of a Benefit Quarter after the Fund Office has received contributions from an Employer or Employers for 300 hours of work during a Contribution Quarter, in accordance with the following schedule:

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

*(C) Initial Eligibility for Newly Organized Employees*

- (1) Employees of Newly Organized Employers who request immediate eligibility shall become eligible for benefits as set forth in this Section 2(a)(i)(C). A Newly Organized Employer is:
  - a. an Employer initially signatory to a new collective bargaining agreement with the Union; or
  - b. an Employer who is currently party to a collective bargaining agreement with the Union who:
    1. enters into an additional or amended collective bargaining agreement covering a unit of the Employer which is a newly organized employer with respect to such bargaining unit; or
    2. purchases or otherwise acquires an entity whose employees become covered by the collective bargaining agreement as a result of such acquisition. The Employer is a newly organized employer with respect to the employees of the acquired entity.
- (2) A Newly Organized Employer, in order to obtain immediate coverage on behalf of its Bargaining Unit Employees, must make a contribution in a uniform amount set by the Trustees for each Employee to the Fund. The contribution must be received prior to the commencement of the eligibility period and upon receipt of the contribution the Employees' coverage will be effective for an initial period of two Months. For Employees to be eligible for immediate coverage, they must not have had prior contributions made on their behalf.
- (3) In order to obtain continued Initial Eligibility coverage for a third Month under this Section, the Employee must work and the Newly Organized Employer must contribute to the Welfare Fund at least 100 hours during the first Month of eligibility on behalf of the eligible Employee, which contributions will be applicable to the third Month of coverage. Each Month thereafter, at least 100 hours must be contributed to maintain monthly eligibility.

- (4) The Initial Eligibility grace period during which an Employer may hire an Employee and obtain immediate eligibility shall be applicable only for a period of twelve months from the effective date of the collective bargaining agreement. All Employees hired after the twelve-month grace period will not be eligible for coverage under this Section and will only be permitted to establish eligibility under the Initial Eligibility requirements set forth in Section 2(a)(i)(B) above. The Employees that are eligible to be added to the immediate coverage must be new hires and must not have had prior contributions made on their behalf to the Welfare Fund.
- (5) An employee of a Newly Organized Employer who had previous coverage under the Midwest Operating Engineers Welfare Fund, but whose coverage lapsed while an Employee of the Employer prior to being organized, and who continues in that employment as an Employee of the Newly Organized Employer shall be considered eligible for immediate coverage.
- (6) An Employee of a Newly Organized Employer will become a regular Bargaining Unit Employee once he has satisfied the initial eligibility rules set forth in Section 2(a)(i)(B) above.

*(D) Continuing Eligibility*

Eligibility shall continue in each Benefit Quarter as long as the Employee:

- (1) continues to meet the requirements set forth in Section 2(a)(i)(B) during each successive quarter; or
- (2) has a combined total of at least 1,200 hours in the applicable Contribution Quarter and the three Contribution Quarters immediately preceding it.

*(E) Work Credits for Eligible Disabled Employees*

If an Eligible Bargaining Unit Employee is receiving Weekly Disability Benefits pursuant to Article 9 or is receiving loss of income benefits under a Worker's Compensation or Occupational Disease Act, he will be entitled to credit for 40 hours per week for each of the first 17 weeks he receives such benefits toward Continuing Eligibility hereunder. A person whose eligibility is based on contributions made under an

Owner/Relative clause of a collective bargaining agreement is not entitled to the credits described in this paragraph.

*(F) Continuing Eligibility Through Self-Payment*

*(1) Self-Payments for Plan A Coverage*

Once an Employee has met the Initial Eligibility requirements set forth in Section 2(a)(i)(B) above, he may make self-payments for up to a maximum of four consecutive Contribution Quarters to continue coverage, provided he is on the out-of-work list and available for work, under the following circumstances:

- a. If an Employee's eligibility is due to terminate because fewer than the needed number of hours as specified in Section 2(a)(i)(D) above were contributed on his behalf, the Employee may self-pay the balance of the remaining hours in an amount equal to the hourly rate specified by the Board of Trustees.
- b. If a disabled Employee's eligibility is due to terminate because fewer than the needed number of hours as specified in Section 2(a)(i)(D) above were contributed, including any hours credited on his behalf as specified in 2(a)(i)(E), the Employee may self-pay the balance of the remaining hours in an amount equal to the hourly rate specified by the Board of Trustees.
- c. Self-payments are due by the 15th day of the month preceding the Benefit Quarter for which coverage is desired; however, the Plan provides a grace period until the 30th day of the Benefit Quarter.

*Section 2(a)(i)(F)(1) amendment by the addition of subparagraph d effective July 1, 2009 (see Amendments Nos. 6 & 7).*

*(2) Self-Payments for Plan C Coverage*

Once an Employee has met the Initial Eligibility requirements set forth in Section 2(a)(i)(B) above, he may decline to make self-payments for Plan A coverage and instead make self-payments for up to a maximum of four consecutive Contribution Quarters for Plan C coverage, provided he is on the out-of-work list and available for work. Plan C benefits are set forth in the Appendix on the Schedule of Benefits for Plan B-1. The Employee may elect to continue eligibility for himself

and/or his Eligible Dependents. The following rules apply to Plan C self-payments and coverage:

- a. If an Employee's eligibility is due to terminate because fewer than the needed number of hours as specified in Section 2(a)(i)(D) above were contributed on his behalf, the Employee may self-pay the balance of the remaining hours in an amount equal to the hourly rate specified by the Board of Trustees.
- b. If a disabled Employee's eligibility is due to terminate because fewer than the needed number of hours as specified in Section 2(a)(i)(D) above were contributed, including any hours credited on his behalf as specified in 2(a)(i)(E), the Employee may self-pay the balance of the remaining hours in an amount equal to the hourly rate specified by the Board of Trustees.
- c. Self-payments are due by the 15th day of the month preceding the Benefit Quarter for which coverage is desired; however, the Plan provides a grace period until the 30th day of the Benefit Quarter.
- d. If an Employee initially elects to make self-payments for Plan A, he will be permitted to drop down to Plan C during the same self-payment period. He cannot go up from Plan C to Plan A for any remaining Eligibility Quarters during that same self-pay period.
- e. The Employee's maximum allowable self-pay period of four consecutive Contribution Quarters does not start over if he drops to Plan C coverage.
- f. Amounts applied to a person's deductibles, Maximum Benefits and other benefit accumulations while he was covered under Plan A will carry over and be applied to his Plan C deductible and benefit accumulations, and vice versa.

*(G) Employee Termination of Eligibility for Plan A Benefits*

Employee eligibility for Plan A benefits shall terminate upon the earliest of the following dates:

- (1) at the end of the last day of the Benefit Quarter for which the Continuing Eligibility requirements have been met;
- (2) when any self-payment is due and unpaid; or
- (3) the date of the Employee's death.

*(H) Reinstatement*

An Employee whose eligibility has been terminated but who returns to work shall become reinstated once he satisfies the Initial Eligibility requirements set forth in Section 2(a)(i)(B) above.

*(I) Dependent Eligibility*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Employee's eligibility is effective or on the date the Employee acquires the Eligible Dependent, whichever is later.

*(J) Dependent Termination of Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- (1) the end of the Benefit Quarter in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- (2) the date the Employee's coverage terminates, except as stated in Sections 2(a)(i)(K) and 2(a)(i)(L) below; or
- (3) the date of the Dependent's death.

*(K) Termination of Dependent Coverage Following the Death of the Employee*

In the event of an Employee's death, and unless the Dependent elects to make self-payments for extended survivor coverage as set forth in the Section 2(a)(i)(L) below, coverage for his spouse and Dependent children will continue until the earliest of the following dates:

- (1) the last day of the Benefit Quarter for which the Employee had satisfied the Continuing Eligibility requirements; or

- (2) the date the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2.

*(L) Survivor Eligibility and Benefits*

- (1) Surviving Dependent spouses of deceased Eligible Employees whose eligibility is due to terminate may elect to continue coverage by making self-payments at the monthly rate specified by the Board of Trustees. The surviving spouse may continue coverage for herself and all Eligible Dependent children who were covered under the Plan on the day before the Employee's death. To be eligible, the following must apply:
  - a. the Employee must have been eligible under this Plan at the time of his death, and
  - b. the Employee must have been eligible under this Plan for at least ten years (40 Benefit Quarters).
- (2) A surviving Dependent spouse's eligibility will terminate at the end of the Month in which the first of the following events occurs:
  - a. the required self-payment is not made;
  - b. the spouse remarries;
  - c. the spouse dies;
  - d. the spouse becomes entitled to coverage under another group policy or plan, including Medicare; or
  - e. the spouse establishes permanent residence outside the continental limits of the United States.
- (3) A surviving Dependent child's eligibility will terminate at the end of the Month in which the first of the following events occurs:
  - a. the surviving Dependent spouse's eligibility terminates for any reason;
  - b. the child no longer meets the definition of Dependent child; or
  - c. the child becomes entitled to coverage under another group policy or plan, including Medicare.

- (4) COBRA Coverage, as described in this Article 3, is also available to qualified Dependent spouses and Dependent children, and can be elected in lieu of Survivor Benefits. Any period of COBRA Coverage will run concurrently with Survivor Benefits as described above. If the Dependent chooses Survivor Benefits and it ends before the expiration of 36-months from the death of the Employee, the Dependent may elect COBRA for the balance of the 36-month period.

(ii) *City of Chicago Employees*

The benefits provided for individuals who meet the eligibility requirements in this Section 2(a)(ii) are set forth in the Appendix on the Schedule of Benefits for Plan A-2.

In accordance with a collective bargaining agreement between the City of Chicago and the Union, employees who were previously covered under this Plan but who would otherwise have lost such coverage when they became employed by the City of Chicago are permitted to make quarterly flat-rate contributions to the Fund for supplemental health benefits. The amount of the required quarterly contribution is determined by the Trustees. In order to be eligible for benefits from this Fund, the Employee must be employed by the City of Chicago and must elect and be eligible for healthcare benefits through the City of Chicago.

(A) *Initial Eligibility*

An Employee shall become eligible for Plan A on the first day of the Benefit Quarter for which he makes the required contribution to the Fund.

(B) *Continuing Eligibility*

Eligibility will be continued as long as the Employee makes the required contribution to the Fund and maintains his group coverage through the City of Chicago.

(C) *Employee Termination of Eligibility*

Employee eligibility for Plan A benefits shall terminate upon the earliest of the following dates:

- (1) at the end of the last day of the Benefit Quarter for which the Employee made the required contribution to the Plan;

- (2) at the end of the Benefit Quarter preceding the Benefit Quarter for which the Employee first fails to maintain his group coverage through the City of Chicago; or
- (3) the date of the Employee's death.

*(D) Reinstatement*

If the Employee's eligibility terminates it cannot be reinstated.

*(E) Dependent Eligibility*

*(1) Initial Eligibility for Dependents*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Employee's eligibility is effective or on the date the Employee acquires the Eligible Dependent, whichever is later.

*(2) Dependent Termination of Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- a. the end of the Benefit Quarter in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- b. the date the Employee's coverage terminates, except that in the event of the Employee's death, the Dependent's eligibility will terminate on the last day of the Benefit Quarter for which the Employee had satisfied the Continuing Eligibility requirements; or
- c. the date of the Dependent's death.

**(b) Monthly Eligibility**

*(i) Non-Bargaining Unit Employees*

The benefits provided for individuals who meet the eligibility requirements in this Section 2(b)(i) are set forth in the Appendix on the Schedule of Benefits for Plan A-3.

*(A) Initial Eligibility*

The Initial Eligibility date for a Non-Bargaining Unit Employee shall be the first day of the Month following 30 con-

secutive days of full-time employment of at least 30 hours per week, provided the Employee is actively at work on that day, and provided that the contribution has been paid in full by the Employer.

*(B) Continuing Eligibility*

Continuing Eligibility will be determined on a Month-to-Month basis as long as the Employee continues in the employ of the Contributing Employer and the Employer makes the required monthly contribution to the Fund on his behalf. The amount of the required monthly contribution is established by the Trustees and set forth in the Employer's participation agreement with the Trustees.

*(C) Declining Coverage*

The terms of the participation agreement allow certain Non-Bargaining Unit Employees to decline eligibility for himself and/or his Dependent(s), and to enroll in the Plan at a later date. Coverage may only be declined and late enrollment is only allowable if the Employee is covered under another group health plan (including Medicare) or health insurance, subject to the following rules:

- (2) The Employee must complete and sign a waiver form, and provide proof of the other group health plan or health insurance coverage that is satisfactory to the Administrative Manager within 60 days of declining Plan eligibility.
- (3) If an Employee declines eligibility for himself or for his Dependent(s), including his spouse, because of other group health plan or health insurance coverage, the Employee may in the future enroll himself and his Dependents in the Plan, provided that the Employee requests enrollment within 60 days after the Employee's other coverage ends due to the exhaustion of the COBRA continuation maximum period of coverage, the termination of employer contributions for coverage in the other plan, or the loss of eligibility in such other plan due to divorce, legal separation, death, termination of employment or reduction in hours. In addition, if the Employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the Employee may enroll himself and his Dependent(s), provided that the Employee

*Section 2(b)(i)(C) amended effective April 1, 2009 (see Amendment No. 5).*

requests enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

*(D) Self-Payments*

Non-Bargaining Unit Employees may not make self-payments to the Fund, other than COBRA payments, to continue their eligibility.

*(E) Employee Termination of Eligibility for Plan A Benefits*

Eligibility for a Non-Bargaining Unit Employee shall terminate upon the earliest of the following dates:

- (1) the last day of the Month for which the Employer made the required contribution to the Plan;
- (2) the last day of the Month in which his employment with the Employer terminates; or
- (3) the date of the Employee's death.

*(F) Dependent Eligibility*

*(1) Initial Eligibility for Dependents*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the later of the following dates:

- a. the date the Employee's eligibility is effective;
- b. the date the Employee acquires the Eligible Dependent; or
- c. subject to the provisions of Section 2(b)(i)(C) above, if the Employee initially declined coverage for himself and the dependent, on the date the Employee subsequently enrolls the Eligibility Dependent.

*(2) Termination of Dependent Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- a. the end of the Month in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;

- b, the date the Employee's coverage terminates, except that in the event of the Employee's death, the Dependent's eligibility will terminate on the last day of the Benefit Quarter for which the Employee had satisfied the Continuing Eligibility requirements; or
- c. the date of the Dependent's death.

(ii) *Staff Employees*

The benefits provided for individuals who meet the eligibility requirements in this Section 2(b)(ii) are set forth in the Appendix on the Schedule of Benefits for Plan A-4.

(A) *Initial Eligibility*

The Initial Eligibility date for a Staff Employee shall be the first day of the Month following the Month in which his employment with the Contributing Employer begins.

(B) *Continuing Eligibility*

Continuing Eligibility for a Staff Employee will be determined on a Month-to-Month basis as long as the Employer makes the required monthly contribution to the Fund on his behalf. The amount of the required monthly contribution is established by the Trustees and set forth in the Contributing Employer's participation agreement with the Trustees.

(C) *Eligibility Credits for Eligible Disabled Employees*

If an Eligible Staff Employee is receiving Weekly Disability Benefits pursuant to Article 9 or is receiving loss of income benefits under a Worker's Compensation or Occupational Disease Act, he will be entitled to credit for up to four Months of eligibility toward Continuing Eligibility hereunder. The first monthly credit will be for the Month following the Month in which he becomes entitled to Weekly Disability Benefits or loss of income benefits due to a work-related Disability.

(D) *Self-Payments*

Staff Employees may not make self-payments to the Fund, other than COBRA payments, to continue their eligibility.

(E) *Employee Termination of Eligibility for Plan A Benefits*

Eligibility for a Staff Employee shall terminate upon the earliest of the following dates:

- (1) the last day of the Month during which the Employee's employment terminates;
- (2) the last day of the Month for which the Employer makes the required contribution to the Fund; or
- (3) the date of the Employee's death.

*(F) Dependent Eligibility*

*(1) Initial Eligibility for Dependents*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Employee's eligibility is effective or on the date the Employee acquires the Eligible Dependent, whichever is later.

*(2) Dependent Termination of Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- a. the end of the Month in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- b. the date the Employee's coverage terminates, except as stated in Sections 2(a)(i)(K) and 2(a)(i)(L) above; or
- c. the date of the Dependent's death.

*(H) Survivor Eligibility and Benefits*

- (1) Surviving Dependent spouses of deceased Eligible Staff Employees whose eligibility is due to terminate may elect to continue coverage by making self-payments at the monthly rate specified by the Board of Trustees. The surviving spouse may continue coverage for herself and all Eligible Dependent children who were covered under the Plan on the day before the Employee's death. To be eligible, the following must apply:
  - a. the Employee must have been eligible under this Plan at the time of his death, and
  - b. the Employee must have been eligible under this Plan for at least ten years (120 Months).

- (2) A surviving Dependent spouse's eligibility will terminate at the end of the Month in which the first of the following events occurs:
  - a. the required self-payment is not made;
  - b. the spouse remarries;
  - c. the spouse dies;
  - d. the spouse becomes entitled to coverage under another group policy or plan, including Medicare; or
  - e. the spouse establishes permanent residence outside the continental limits of the United States.
- (3) A surviving Dependent child's eligibility will terminate at the end of the Month in which the first of the following events occurs:
  - a. the surviving Dependent spouse's eligibility terminates for any reason;
  - b. the child no longer meets the definition of Dependent child; or
  - c. the child becomes entitled to coverage under another group policy or plan, including Medicare.
- (4) COBRA Coverage, as described in this Article 3, is also available to qualified Dependent spouses and Dependent children, and can be elected in lieu of Survivor Benefits. Any period of COBRA Coverage will run concurrently with Survivor Benefits as described above. If the Dependent chooses Survivor Benefits and it ends before the expiration of 36-months from the death of the Employee, the Dependent may elect COBRA for the balance of the 36-month period.

(iii) *Owner/Relatives*

The benefits provided for individuals who meet the eligibility requirements in this Section 2(b)(iii) are set forth in the Appendix on the Schedule of Benefits for Plan A-4.

(A) *Initial Eligibility*

Initial Eligibility for an Owner/Relative shall be the first day of the Month for which the Employer is required to make a contribution to the Fund.

(B) *Continuing Eligibility*

Continuing Eligibility will be determined on a Month-to-Month basis as long as the Employer makes the required monthly contribution to the Fund on his behalf. The amount of the required monthly contribution is established by the Trustees and set forth in the Employer's participation agreement with the Trustees.

(C) *Self-Payments*

Owner/Relatives may not make self-payments to the Fund.

(D) *Employee Termination of Eligibility for Plan A Benefits*

An Owner/Relative's eligibility for Plan A benefits shall terminate upon the earliest of the following dates:

- (1) at the end of the last day of the Month for which the Contributing Employer made the required contribution to the Plan;
- (2) the last day of the Month in which his employment with the Employer terminates;
- (3) the last day of the Month before the Month in which the Employer is no longer signatory to a participation agreement allowing contributions to be made to the Plan;  
or
- (4) the date of the Employee's death.

(E) *Dependent Eligibility*

(1) *Initial Eligibility for Dependents*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Owner/Relative's eligibility is effective or on the date the Owner/Relative acquires the Eligible Dependent, whichever is later.

(2) *Termination of Dependent Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- a. the end of the Month in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- b. the date the Employee's coverage terminates, except as stated in Sections 2(a)(i)(K) and 2(a)(i)(L) above; or
- c. the date of the Dependent's death.

(iv) *Municipalities*

The benefits provided for individuals who meet the eligibility requirements in this Section 2(b)(iv) are set forth in the Appendix on the Schedule of Benefits for Plan A-5.

(A) *Initial Eligibility*

The Initial Eligibility date for a Municipality Employee shall be the first day of the Month following the Month in which his employment with the Contributing Employer begins.

(B) *Continuing Eligibility*

Continuing Eligibility will be determined on a Month-to-Month basis as long as the Employer makes the required monthly contribution to the Fund on his behalf. The amount of the required monthly contribution is established by the Trustees and set forth in the Employer's participation agreement with the Trustees.

(C) *Self-Payments*

Municipality Employees may not make self-payments to the Fund, other than COBRA payments, to continue their eligibility.

(D) *Employee Termination of Eligibility for Plan A Benefits*

Eligibility for a Municipality Employee shall terminate upon the earliest of the following dates:

- (1) the last day of the Month during which the Employee's employment terminates;

- (2) the last day of the Month for which the Employer makes the required contribution to the Fund; or
- (3) the date of the Employee's death.

*(E) Dependent Eligibility*

*(1) Initial Eligibility for Dependents*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Employee's eligibility is effective or on the date the Employee acquires the Eligible Dependent, whichever is later.

*(2) Termination of Dependent Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- a. the end of the Month in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- b. the date the Employee's coverage terminates, except that in the event of the Employee's death, the Dependent's eligibility will terminate on the last day of the Month for which the Employee had satisfied the Continuing Eligibility requirements; or
- c. the date of the Dependent's death.

**Section 3. Eligibility for Employees in Plan B.**

The Plan provides a level of benefit coverage called "Plan B" for certain active Employees (sometimes referred to as "plantmen") whose Employers have entered into a collective bargaining agreement with the Union under which the Employer makes contributions to the Plan for the benefits provided under the Plan B Schedule of Benefits. The amount of the required monthly contribution is determined by the Trustees.

**(a) Monthly Eligibility**

The benefits provided for individuals who meet the eligibility requirements in this Section 3(a) are set forth in the Appendix on the Schedule of Benefits for Plan B-1.

(i) *Initial Eligibility*

An Employee shall become eligible for Plan B on the first day of the Month following the Month during which the Contributing Employer's initial contribution for the Employee is due to the Fund. For example, if an Employee begins working in March, the initial contribution is due in April, and the Employee will become initially eligible on May 1. In this example, March is the Work Month and May is the corresponding Eligibility Month.

(ii) *Continuing Eligibility*

An Employee shall remain eligible during each successive Eligibility Month as long the Employer makes the required monthly contribution to the Fund on his behalf for the corresponding Work Month. The amount of the required monthly contribution is established by the Trustees and set forth in the Contributing Employer's collective bargaining agreement with the Trustees.

(iii) Self-Payments

Each Calendar Year, Plan B Employees who previously established initial eligibility and whose coverage would otherwise terminate at the end of their work periods may make up to four monthly self-payments to the Fund to continue their eligibility. Self-payments must be received by the Administrative Manager by the first of that Eligibility Month, except that a 30-day grace period shall be provided. This 4-month self-pay period will run concurrently with the Employee's COBRA Coverage period.

(iv) Employee Termination of Eligibility for Plan B

Eligibility for a Plan B Employee shall terminate upon the earliest of the following dates:

- (A) the last day of the Eligibility Month for which the Continuing Eligibility requirements have been met;
- (B) when any self-payment is due and unpaid; or
- (C) the date of the Employee's death.

(v) *Dependent Eligibility*

(A) *Dependent Eligibility*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Employee's eligibil-

ity is effective or on the date the Employee acquires the Eligible Dependent, whichever is later.

*(B) Dependent Termination of Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- (1) the end of the Month in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- (2) the date the Employee's coverage terminates, except that in the event of the Employee's death, the Dependent's eligibility will terminate on the last day of the Month for which the Employee had satisfied the Continuing Eligibility requirements; or
- (3) the date of the Dependent's death.

**Section 4. Eligibility for Employees in Plan D.**

The Plan provides a level of benefit coverage called "Plan D" for active Employees whose Employers make contributions to the Plan for Dental Benefits only. The amount of the required monthly contribution is determined by the Trustees.

The benefits provided for individuals who meet the eligibility requirements in this Section 4 are set forth in the Appendix on the Schedule of Benefits for Plan D-1.

**(a) Initial Eligibility**

An Employee shall become eligible for Plan D on the first day of the Month following the date his employment with the Contributing Employer begins.

**(b) Continuing Eligibility**

Continuing Eligibility will be determined on a Month-to-Month basis as long as the Employer makes the required monthly contribution to the Fund on his behalf. The amount of the required monthly contribution is established by the Trustees.

**(c) Self-Payments**

Plan D Employees may not make self-payments to the Fund, other than COBRA payments, to continue their eligibility.

**(d) Employee Termination of Eligibility for Plan D**

Eligibility for a Plan D Employee shall terminate upon the earliest of the following dates:

- (i) the last day of the Month during which the Employee's employment terminates;
- (ii) the last day of the Month for which the Employer makes the required contribution to the Fund; or
- (iii) the date of the Employee's death.

**(e) Dependent Eligibility**

*(i) Initial Eligibility for Dependents*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Employee's eligibility is effective or on the date the Employee acquires the Eligible Dependent, whichever is later.

*(ii) Termination of Dependent Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- (A) the end of the Month in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- (B) the date the Employee's coverage terminates, except that in the event of the Employee's death, the Dependent's eligibility will terminate on the last day of the Month for which the Employee had satisfied the Continuing Eligibility requirements; or
- (D) the date of the Dependent's death.

**Section 5. Eligibility for Employees in Plan E.**

The Plan provides a level of benefit coverage called "Plan E" for active Employees whose employment is covered by a collective bargaining agreement between the Illinois Landscape Contractors Bargaining Association and the Union. The amount of the required monthly contribution is determined by the Trustees.

The benefits provided for individuals who meet the eligibility requirements in this Section 5 are set forth in the Appendix on the Schedule of Benefits for Plan E-1.

**(a) Initial Eligibility**

An Employee shall become eligible for Plan E on the first day of the Month following 31 days of employment with the Contributing Employer.

**(b) Continuing Eligibility**

Continuing Eligibility will be determined on a Month-to-Month basis as long as the Employer makes the required monthly contribution to the Fund on his behalf. The amount of the required monthly contribution is established by the Trustees.

**(c) Self-Payments**

Plan E Employees may not make self-payments to the Fund, other than COBRA payments, to continue their eligibility.

**(d) Employee Termination of Eligibility for Plan E**

Eligibility for a Plan E Employee shall terminate upon the earliest of the following dates:

- (i) the last day of the Month during which the Employee's employment terminates;
- (ii) the last day of the Month for which the Employer makes the required contribution to the Fund; or
- (iii) the date of the Employee's death.

**(f) Dependent Eligibility**

*(i) Initial Eligibility for Dependents*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Employee's eligibility is effective or on the date the Employee acquires the Eligible Dependent, whichever is later.

*(ii) Termination of Dependent Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- (A) the end of the Month in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- (B) the date the Employee's coverage terminates, except that in the event of the Employee's death, the Dependent's eligibility

will terminate on the last day of the Month for which the Employee had satisfied the Continuing Eligibility requirements; or

- (C) the date of the Dependent's death.

**Section 6. Reciprocity.**

- (a) If an Employee of a Contributing Employer is required by such Employer to temporarily perform work outside the geographical jurisdiction of the Union, such Employee will continue to be eligible as though employed within the geographical jurisdiction of the Union, if the Employee signs an authorization form provided by the Fund, and if the Employer has made the required Contributions to the Fund on the Employee's behalf during the period of outside employment. Only contributions made in accordance with the specific Reciprocity Agreement can be accepted under this Section.
- (b) In the case of an Employee on whose behalf Contributions are transmitted to the Trust Fund by a cooperating welfare fund, under a reciprocal agreement entered into, as authorized by the Board of Trustees, hours of work for the purpose of continued eligibility hereunder shall be credited to such an Employee as hereafter provided that the total sum of Employer Contributions transmitted to the Fund Office on behalf of such an Employee, for a specified Contribution Quarter, shall be divided by the hourly contribution rate in the Heavy and Highway Agreement for District 1. The quotient shall be the number of hours of work to be credited to such an Employee for the specified Contribution Quarter.
- (c) Based on the above provisions of this Section 6, Continuing Eligibility of any such Employee shall then be determined in accordance with this Article 3.

**Section 7. Continuation of Coverage During Leave of Absence (FMLA)**

Eligible Employees may be able to continue medical benefits under the Family and Medical Leave Act of 1993 (FMLA). Only Eligible Employees of Contributing Employers who are obligated to comply with the FMLA are eligible for this continuation.

**(a) Continuing Health Coverage**

The Contributing Employer must:

- (i) notify the Administrative Manager when a FMLA leave is granted; and
- (ii) if the Employee's eligibility is determined on a quarterly basis, make contributions for each Month based on the average monthly contributions made on the Employee's behalf over the last five years; or
- (iii) if the Employee's eligibility is determined on a monthly basis, make the required payments on a timely basis.

**(b) Maintenance of Health Benefit**

A Contributing Employer must continue to make contributions for an Eligible Employee while he is on FMLA leave. Notice must be made on the remittance form and the contributions must be sent to the Administrative Manager.

**(c) Termination of the FMLA Obligation to Maintain Health Care Coverage**

The Fund's obligation to maintain health care coverage during a FMLA leave ends on the earliest of the following dates:

- (i) when an Employee returns to work;
- (ii) when twelve (12) weeks of FMLA leave ends; or
- (iii) when the Employer ceases to make contributions to the Fund to continue the Employee's coverage.

**(d) Interaction with COBRA**

The Employee's FMLA leave period will run concurrently with his COBRA Coverage period and any period during which his eligibility is extended due to Disability.

**(e) Disputes over Eligibility and Coverage**

All disputes over an Eligible Employee's eligibility under FMLA are between the Employee and Contributing Employer. Benefits will be suspended pending resolution of the dispute. The Trustees will have no direct role in resolving such a dispute.

**Section 8. Military Service**

**(a) Eligibility Freeze During Active Duty**

If an Eligible Employee leaves employment with a Contributing Employer to serve in the U.S. military, his accumulated eligibility may either be frozen during his military service or used to continue eligibility for his Dependents. The eligibility freeze is the default option. Under a freeze the Employee's accumulated eligibility, if any, will be frozen until he returns to work with the Employer. During the freeze period, neither the Employee nor his Dependents will be eligible for Plan benefits unless the Employee elects to make self-payments as described in Section 8(b)(ii)(A) below. After the Employee returns to covered employment, the eligibility he accumulated before his military duty period will be reinstated. An Employee may decline a freeze by contacting the Administrative Manager and authorizing use of his accumulated eligibility to provide eligibility for his Dependents. After that eligibility period ends, the Employee may elect to continue coverage for his Dependents by making self-payments as described in Section 8(b)(ii)(A).

**(b) Uniformed Services Employment and Reemployment Rights (USERRA)**

Eligible Employees and Dependents may be able to continue medical benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

*(i) Definitions for Purposes of this Section 8 Only*

- (A) "Health Coverage" means Hospital, surgical, medical, or prescription drug coverage provided under the Plan. Health Coverage is subject to change as a result of Plan modifications.
- (B) "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such Act and any interpretive regulations or rulings).
- (C) "Service in the uniformed services" means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for

the purpose of an examination to determine the fitness of the person to perform any such duty.

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

(ii) *Continuation of Group Health Coverage*

- (A) For an Employee and his eligible Dependents: If Health Coverage ends because of an Employee’s service in the uniformed services, an Employee or Dependent may elect to continue such Health Coverage until 24 consecutive months after coverage ended. This 24-month period will run concurrently with the Employee’s COBRA Coverage period.
- (B) To continue coverage, an Employee or his Dependent must pay the required contribution amount unless service in the uniformed service is for fewer than 31 days, in which case an Employee must pay his share, if any, of the premium. The Administrative Manager will inform an Employee or his Dependent of procedures to pay premiums.

(iii) *Other Continuation Provisions*

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

(iv) *Reemployment Following Uniformed Service*

Following discharge from such service, an Employee may be eligible to apply for reemployment with his former Contributing Employer in accord with USERRA. Such reemployment includes the right to elect reinstatement in any then existing health coverage provided by the Contributing Employer, and if the returning Employee declined to make self-payments to continue his coverage during his military leave, he may elect to make such self-payments upon his reemployment.

(v) *End of Continuation*

A covered person's continued Health Coverage will end at midnight on the earliest of:

- (A) the day an Employee's former Contributing Employer ceases to provide any group health plan to any Employee;
- (B) the day premium is due and unpaid;
- (C) the day a covered person again becomes covered under the Plan; or
- (D) the day Health Coverage has been continued for the period of time provided in Section 8(b)(ii)(A) above (or any longer period provided in the Plan).

(vi) *In the Event of Conflicting Provisions*

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by an Employee's Contributing Employer or former Contributing Employer, shall apply.

**Section 9. COBRA Coverage.**

Pursuant to the provisions of the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") and regulations issued thereunder, the Fund shall offer Qualified Beneficiaries the opportunity for a temporary extension of health coverage ("COBRA Coverage") on a self-pay basis upon the occurrence of a Qualifying Event as defined below. COBRA Coverage only applies to the health coverage (including dental benefits) available under the Plan, and shall not include continuation of coverage for death benefits, accidental dismemberment coverage or weekly disability benefits. The following COBRA provisions shall be interpreted in accordance with the developing regulatory and case law under COBRA, since it is the intent of the Trustees, in their capacity as sponsor of this Plan, to meet the requirements of COBRA.

*Section 9 introductory paragraph amended effective July 1, 2009 (see Amendment No. 7).*

**(a) Definition of Qualified Beneficiary**

- (i) A "Qualified Beneficiary" is any person who, as of the day before a Qualifying Event, is an Eligible Employee covered under the Plan as of such day, the spouse of the Eligible Employee, who is covered as an Eligible Dependent under the Plan as of such day, or a child of the Eligible Employee, who is covered as an Eligible Dependent under the Plan as of such day.

- (ii) A Dependent born to the Employee, adopted by the Employee or placed for adoption with the Employee during a period of COBRA Coverage is also a Qualified Beneficiary.

**(b) Qualifying Events**

Any of the following shall be considered to be a Qualifying Event if it would cause the Qualified Beneficiary to lose coverage under the Plan were it not for the continuation of coverage provisions of this Section.

*(i) Qualifying Events for an Eligible Employee*

A Qualified Beneficiary who is an Eligible Employee shall have the right to choose COBRA Coverage for himself if he loses coverage under the Plan because of the termination of his employment (for reasons other than gross misconduct) or a reduction in hours of employment, which includes, but is not limited to, layoff, strike, Disability, medical leave of absence or retirement.

*(ii) Qualifying Events for Eligible Dependents (Spouse and Children)*

(A) A Qualified Beneficiary who is the Dependent spouse of an Eligible Employee shall have the right to choose COBRA Coverage for himself if he loses coverage under the Plan for any of the following reasons:

- (1) the death of the Eligible Employee;
- (2) the termination of the Eligible Employee's employment (for reasons other than gross misconduct) or reduction of the Eligible Employee's hours of employment;
- (3) divorce or legal separation from the Eligible Employee;  
or
- (4) the Eligible Employee's becoming entitled to Medicare.

(B) A Qualified Beneficiary who is a Dependent child of an Eligible Employee, shall have the right to choose COBRA Coverage if his coverage under the Plan is lost for any of the following reasons:

- (1) the death of the Eligible Employee;
- (2) the termination of the Eligible Employee's employment (for reasons other than gross misconduct) or reduction of the Eligible Employee's hours of employment;
- (3) divorce or legal separation of the Eligible Employee;

- (4) the Eligible Employee's becoming entitled to Medicare; or
- (5) he ceases to be an Eligible Dependent as defined under this Plan.

**(c) Notice and Election of COBRA Coverage**

- (i) In order to qualify for COBRA Coverage, the Qualified Beneficiary has the responsibility to inform the Administrative Manager at the Fund Office immediately after a divorce, legal separation, or if a child ceases to satisfy the definition of "Eligible Dependent child" in the Plan. If the Qualified Beneficiary does not report such event to the Administrative Manager within 60 days after loss of coverage due to the event, COBRA Coverage will not be available.
- (ii) It is the responsibility of the Eligible Employee's Contributing Employer to notify the Administrative Manager within 45 days of the Eligible Employee's death, termination of employment, or reduction in hours which causes a loss of medical benefits under the Plan, or the Eligible Employee's entitlement to Medicare. However, the Eligible Employee or other family member should notify the Administrative Manager if any of these Qualifying Events occurs in order to assure timely notification of eligibility for, and processing of, an election of COBRA Coverage.
- (iii) Each Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act, to have been disabled at the time, or within 60 days, of a Qualifying Event must notify the Administrative Manager at the Fund Office of such determination within 60 days after the determination. Each Qualified Beneficiary who has been determined to have been disabled at the time of a Qualifying Event must notify the Administrative Manager at the Fund Office within 30 days of the date of any final determination under Title II or Title XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.
- (iv) When the Administrative Manager is notified that a Qualifying Event has occurred, the Administrative Manager will notify all Qualified Beneficiaries within 14 days of their right to choose COBRA Coverage by submitting the appropriate election. Notification to a Qualified Beneficiary who is a spouse of an Eligible Employee is treated as notification to all other Qualified Beneficiaries residing with that person at the time notification is made.

- (v) The Administrative Manager must receive the election at least 60 days from the later of the date coverage terminated or will terminate under the Plan or the date of the notice advising of rights to COBRA Coverage. The Qualified Beneficiary does not have to show that he is insurable to choose COBRA Coverage. If the Qualified Beneficiary does not choose COBRA Coverage within the 60-day time limit, his coverage under the Plan will not be continued.

**(d) Benefits Available Under COBRA Coverage**

*Section 9(d)  
amended effective  
July 1, 2009 (see  
Amendment No. 7).*

COBRA Coverage benefits are the same benefits to which the Qualified Beneficiary was entitled at the time his Qualifying Event occurred. However, COBRA Coverage does not include Death, Accidental Dismemberment or Weekly Disability Benefits, regardless of when or by whom COBRA Coverage is elected.

**(e) Cost of Coverage; Payment Due Dates**

- (i) Entitlement to COBRA Coverage shall be conditioned upon payment of monthly contributions determined annually by the Trustees, which shall not exceed 102% of the cost for providing health benefits to individuals in the same benefits selection situation as the Qualified Beneficiary. However, the Trustees, in their discretion, may charge an amount up to, but not exceeding 150% of the cost for providing health benefits to individuals in the same benefits selection situation as the Qualified Beneficiary during the 19th through the 29th Month of coverage for a Qualified Beneficiary who elects extended coverage because of Disability. The Administrative Manager will provide specific cost information to the Qualified Beneficiary along with notice of eligibility for COBRA Coverage.
- (ii) Contributions for the period of COBRA Coverage through the Month in which the election is made must be received by the Administrative Manager within 45 days after the date of the election. Contributions for each Month subsequent to the Month in which the election was made must be received by the Administrative Manager by the first of that Month, except that a 30-day grace period shall be provided.

**(f) Maximum Coverage Periods; Termination of COBRA Coverage**

*(i) Maximum Coverage Periods*

COBRA Coverage shall extend for the maximum periods set forth below, or until the occurrence of an event described in Section 9(g) below, if earlier.

- (A) Qualified Beneficiaries who are Eligible Dependents will be afforded the opportunity to continue health coverage for 36 Months after the Qualifying Event (commencing on the date coverage would otherwise terminate), except in the case where the Qualifying Event is the Eligible Employee's loss of coverage due to termination of employment or reduction in hours, in which case the COBRA Coverage period for all Qualified Beneficiaries (including the Eligible Employee) is 18 Months after the Qualifying Event. However, if a Qualified Beneficiary who is an Eligible Dependent is receiving COBRA Coverage for the 18-Month period and another Qualifying Event occurs, e.g., the Eligible Employee dies, the Eligible Dependent is eligible to have COBRA Coverage extended to a total of 36 Months from the date of the first Qualifying Event.
- (B) In the case of a Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act, to have been disabled at the time or within 60 days of the Qualifying Event involving the Eligible Employee's loss of coverage due to termination of employment or reduction in hours, the maximum period of COBRA Coverage is extended from 18 Months to 29 Months, provided that the Qualified Beneficiary has provided the required notice of such determination to the Fund within the original COBRA continuation period of 18 Months. In addition, other family members who had elected COBRA Coverage can keep it for the extended period if they choose. In the event that the Qualified Beneficiary is finally determined under Title II or Title XVI of the Social Security Act to no longer be disabled, the period of extended COBRA Coverage beyond the 18 Months shall terminate at the end of the Month beginning at least 30 days after the date of the final determination that the Qualified Beneficiary no longer is disabled.

**(g) Termination of COBRA Coverage**

Regardless of which continuation period applies, a Qualified Beneficiary's COBRA Coverage shall terminate upon the occurrence of any of the following events:

- (i) The Contributing Employer ceases to maintain this Plan (that is, the Contributing Employer no longer has an obligation to contribute to the Fund for any Eligible Employees). The cessation of COBRA Coverage under this Plan pursuant to this paragraph does not alter any obligation a Contributing Employer may have to provide COBRA Coverage;
- (ii) The Qualified Beneficiary fails to make a required premium payment when due (including the 30-day grace period);
- (iii) The Qualified Beneficiary becomes covered under another group health plan which provides substantially similar benefits after the commencement of this COBRA Coverage, unless such health plan contains an exclusion or limitation with respect to a preexisting condition that such Qualified Beneficiary has; or
- (iv) The Qualified Beneficiary becomes entitled to Medicare.

**Section 10. Termination of Eligibility.**

**(a) Date and Time of Termination**

If an Employee or Dependent loses eligibility in accordance with the provisions set forth in this Article, the person's benefits will terminate at midnight on the specified date.

**(b) Termination of Plan**

In addition to the events set forth in this Article that will cause an Employee or Dependent to lose eligibility under this Plan, eligibility and coverage for all persons will cease on the date the Plan terminates.

**Section 11. Certification of Coverage.**

When an Eligible Employee's coverage under this Plan ends, the Fund shall provide such Employee and his Eligible Dependents with a certificate of coverage that indicates the period of time the person was covered under the Plan, and certain additional information that is required by federal law. The certificate will be sent by first class mail shortly after the individual's coverage under this Plan ends. If the individual elects COBRA Coverage, another certificate will be provided shortly after the COBRA Coverage ends. In addition, a certificate shall be

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provided upon receipt of a request for such certificate if that request is received by the Fund within two years after the later of the date coverage under this Plan ended or the date COBRA Coverage ended.

## ARTICLE 4 – GENERAL PROVISIONS

### Section 1. Funding.

- (a) All Contributing Employers shall make contributions as required under their collective bargaining agreements with the Union, as well as any and all contributions otherwise required by law.
- (b) All contributions made under the Plan shall be held in trust in the Fund until disbursed for payment of benefits (including payment of premiums on insurance to provide benefits) or administrative expenses. The income, expenses, assets and liabilities of the Plan shall be accounted for separately from those of any other plan whose assets are held in the Fund. No assets of any other plan held in the Fund shall be used to pay benefits under this Plan.
- (c) The Trustees may, in their discretion, use assets of the Plan to purchase insurance to provide any benefit under the Plan. In addition, the Trustees may, in their discretion, use assets of the Plan to purchase “excess” or “stop-loss” insurance, provided that such “excess” or “stop-loss” insurance is no more than a financial device of the Plan intended to protect the Plan assets against large losses, meaning that the Trustees (or the Plan) are the named insured, in the event of an insurable event reimbursement under such insurance flows directly from the insurer to the Plan, and no Participant has any rights of any kind under such “excess” or “stop-loss” coverage.
- (d) Except to the extent insured, all benefits under the Plan shall be paid from the assets of the Plan held in the Fund. Neither the Union nor any Contributing Employer nor any Trustee shall have any liability for payment of benefits under the Plan.
- (e) All benefits under this Plan are conditioned upon the sufficiency of the assets of the Plan to provide them. No benefit under this Plan is due if the assets of Plan are insufficient to provide it.

### Section 2. Administration.

The Trustees shall have all rights, duties and powers necessary or appropriate for the administration of the Plan. In particular, the Trustees shall have and shall exercise complete discretionary authority to construe, interpret and apply

all of the terms of the Plan, including all matters relating to eligibility for benefits, amount, time or form of payment, and any disputed or allegedly doubtful terms. The Trustees may employ or retain the services of one or more individuals to carry out the day-to-day administration of the Plan on behalf of the Trustees, of whom the chief executive is the Administrative Manager.

**Section 3. Right to Receive and Release Necessary Information.**

The Trustees have the right to obtain or provide any information needed to process claims and to coordinate benefit payments with other plans. This information may be obtained from or provided to any insurance company, organization, or person without notice to the Participant and without the Participant's consent. Any such uses and disclosures that involve protected health information will comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Section 4. Right to Make Payment.**

The Trustees have the right to pay benefits to any other organization or person as needed to properly carry out the provisions of the Plan. Those payments that are made in good faith are considered benefits paid under this Plan.

**Section 5. Alternate Benefit Provisions.**

The Trustees may pay for or provide services or equipment that they deem to be Medically Necessary, but not otherwise covered by the Plan, if in their sole discretion, they conclude that paying for or providing such services or equipment would be financially beneficial to the Plan. No such payment or providing of services or equipment shall be deemed to be an amendment to the Plan or establish a precedent, nor shall it obligate such payments or providing of services or equipment in the case of any subsequent claim. The Trustees may, but shall not be required to, delegate to their Administrative Manager the authority to authorize such payments pursuant to written rules of uniform application that they adopt from time to time.

**Section 6. Right of Recovery.**

Whenever payments have been made by the Trustees with respect to charges in a total amount at any time in excess of the maximum amount of payment required under the provisions of this Plan, the Trustees shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Trustees shall determine:

- (a) any persons (including family members) to or for or with respect to whom such payments were made;
- (b) any insurance companies; and
- (c) any other organizations.

**Section 7. Workers' Compensation Not Affected.**

The Plan is not in lieu of and does not affect any requirements for coverage by the applicable Workers' Compensation laws of any state.

**Section 8. Amendment and Termination.**

In order that the Trustees may carry out their obligation to maintain, within the limits of the funds available to them, a sound and economical program dedicated to providing the maximum benefits for Participants, the Trustees expressly reserve the right in their sole discretion and without prior notice to Participants, Contributing Employers, the Union and others affected hereby, acting in accordance with the provisions of the Trust Agreement regarding Trustee acts, to amend or terminate the Plan in whole or in part at any time.

**Section 9. Claim Filing Procedures.**

- (a) In order for the Plan to pay benefits, a claim must be filed with the Administrative Manager (or the office designated for handling the claim) in accordance with the procedures described below. A claim can be filed by an Employee, a Retiree, a Dependent or by someone authorized to act on behalf of the Employee, Retiree or Dependent.
- (b) A claim is considered to have been filed on the date it is received at the correct claims office, even if the claim is incomplete.
- (c) A "claim" is a request for Plan benefits, normally because the claimant has incurred a healthcare expense.
- (d) Claims must be filed within one year (twelve months) after the expense was incurred. It is the Participant's responsibility to see that claims and medical bills are submitted promptly and no later than the time period permitted under the Plan. However, written notice of death upon which a claim may be based must be given to the Fund Office within a reasonable period after the date of death. If the Fund Office requests additional information from the Participant or provider in order to process a claim, the requested information must be provided within the time

*Section 9(d)  
amended effective  
January 1, 2009  
(see Amendment  
No. 4).*

period specified on the written request, or within one year from the date of service, whichever is later.

- (e) Claims must:
  - (i) Be written or electronically submitted in accordance with the Electronic Data Interchange standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
  - (ii) Be received by the claims office within one year of the date the claim was incurred;
  - (iii) Include the Participant's and patient's full names, Social Security numbers and/or medical I.D. numbers, the specific medical condition or symptom, and must be itemized by date of service, amount charged, and the specific type of service provided, identify the provider by name, address, telephone number, professional degree or license and federal tax identification number; and
  - (iv) For pre-service claims, in addition to the information in Section 9(e)(iii) above, all pertinent medical information concerning the patient's medical condition and the proposed treatment, including but not limited to the following:
    - (A) medical history and physical;
    - (B) progress notes;
    - (C) medical records;
    - (D) laboratory results and pathology reports;
    - (E) X-rays and radiologists' reports; and
    - (F) operative reports and anesthesia reports.
  - (v) When another plan or Medicare is primary, include a copy of the other plan's explanation of benefits (EOB).
- (g) The claimant may designate another person as his authorized representative for the purposes of filing a claim. Except in the case of an urgent care claim, such designations must be in writing from the claimant (unless the claimant is a child) and include the representative's name, address and telephone number. If the claimant is unable to provide a written statement, the Plan requires written proof such as a legal power or attorney for health care purposes, or a court order of guardianship or conservatorship showing that the representative has been authorized to act on the claimant's behalf. The designation shall be valid for one year,

or as mandated by a court order. The claimant may revoke a designated authorized representative at any time by submitting a written statement. The Trustees, or their designated representative, have the sole discretion to determine whether the claimant has properly designated an authorized representative. The Plan reserves the right to withhold information from a person who claims to be the authorized representative if there is suspicion about the qualifications of the individual claiming to be the authorized representative.

- (h) Unless the authorization states otherwise, all notices regarding the claim will then be sent to the authorized representative and not to the claimant.
- (i) A routine assignment of benefits so that the Plan will pay the provider directly is not a designation of the provider as an authorized representative.

#### **Section 10. Claim Processing.**

##### **(a) Types of Claims**

The amount of time the Plan can take to process a claim depends on the type of claim. A claim can fall into one of the following categories:

- (i) A claim is “post-service” if the treatment or supply for which payment is now being requested has already been received.
- (ii) A “disability claim” is a claim for Weekly Disability Benefits.
- (iii) A “pre-service claim” is a request for preauthorization of a type of treatment or supply that requires approval in advance of obtaining the care. A request for confirmation of Plan coverage is not a claim if the expense has not yet been incurred, unless the Plan conditions payment on the receipt of prior approval. A general inquiry about eligibility or coverage when no expense has been incurred is not a claim, nor is presenting a prescription to a pharmacy.
- (iv) An “urgent care claim” is a pre-service claim where the application of the time periods for making non-urgent care determinations could seriously jeopardize the claimant’s life, health, or ability to regain maximum function, or that could subject the claimant to severe pain that cannot be adequately managed without the proposed treatment.

- (v) A “concurrent care claim” is another type of pre-service claim. A claim is a concurrent care claim if a request is made to extend a course of treatment beyond the period of time or number of treatments previously approved.

**(b) Processing Time**

If all the information needed to process the claim is provided to the claims office, the claim will be processed as soon as possible. However, the processing time needed will not exceed the time frames allowed by law, which are as follows:

- (i) 30 days for post-service claims;
- (ii) 45 days for disability claims;
- (iii) 15 days for pre-service claims;
- (iv) 72 hours for urgent care claims; and
- (v) 24 hours for concurrent care claims if the concurrent care is urgent and if the request for the extension is made within 24 hours prior to the end of the already authorized treatment. If the concurrent care is not urgent, then the pre-service time limits apply.

**(c) When Additional Information Is Needed**

- (i) If additional information is needed from the claimant or the claimant’s doctor or provider, the necessary information or material will be requested in writing. The request for additional information will be sent within the normal time limits shown above, except that the additional information needed to decide an urgent care claim will be requested within 24 hours.
- (ii) It is the claimant’s responsibility to see that the missing information is provided to the claims office. The normal processing period will be extended by the time it takes the claimant to provide the information, and the processing time period will start to run once the claims office has received a response to its request. If the claimant does not provide the missing information within 45 days (48 hours for an urgent care claim), the claims office will make a decision on the claim without it, and the claim could be denied as a result.

**(d) Plan Extension**

The time periods in subsection (c) above may be extended if the claims office determines that an extension is necessary due to matters beyond its control (but not including situations where it needs to request additional information from the claimant or the provider). The claimant will be notified prior to the expiration of the normal approval/denial time period if an extension is needed. If an extension is needed, it will not last more than:

- (i) 15 days for post-service claims;
- (ii) 30 days for disability claims (a second 30-day extension may be needed in special circumstances); and
- (iii) 15 days for pre-service claims.

**(e) Claim Denials**

If all or a part of a claim is denied after the claims office has received all other necessary information from the claimant, the claimant will be sent a written notice stating the reasons for the denial. The notice will include reference to the Plan provisions on which the denial was based and an explanation of the claim appeal procedure. If applicable, it will give a description of any additional material or information necessary for the claimant to perfect the claim, and the reason such information is necessary. The notice will provide a description of the appeal procedures and the applicable time limits for following the procedures. It will also include a statement concerning the claimant's right to bring a civil action under Section 502(a) of ERISA. In cases where the Plan relied upon an internal rule, guideline, protocol or similar criterion to make its decision, the notice will state that the specific internal rule, guideline, protocol or criterion will be provided to the claimant free of charge upon request. If the decision was based on medical necessity or if the treatment was deemed experimental or investigative, the notification will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. For urgent claims, a description of the Plan's expedited review process will be provided.

**Section 11. Claim Appeal Procedures.**

- (a) If a claim has been denied in whole or in part, the claimant may request a full and fair review (also called an "appeal") in accordance with provisions set forth in this Section 11.

- (b) A notice of appeal must be submitted within 180 days after the claimant receives the written notice of denial of the claim. The appeal is considered to have been filed on the date the written notice of appeal is received by the office designated by the Trustees for receiving appeals.
- (c) The Review Panel will be the Board of Trustees or a committee of the Board of Trustees. The Review Panel will not include the person, or a subordinate of the person, who made the original claim denial.
- (d) The Plan has a two-level process for pre-service and post-service health care claims appeals submitted to the Review Panel.
  - (i) The initial written appeal must be submitted to the Fund Office, except in the case of an urgent care or pre-service claim appeal which may be presented verbally.
  - (ii) If the initial appeal is denied, the claimant may submit a second-level appeal of a pre-service or post-service health care claim to the Review Panel at the address of the Administrative Manager. Second-level appeals must be submitted within 30 days of the date of the notice that the initial appeal was denied.
- (e) The claimant may designate an authorized representative as set forth in Section 9(g) above to represent him in connection with an appeal. Except in the case of an urgent care claim, the claimant's designation of an authorized representative must be in writing on a form provided by the Plan. An assignment of benefits is not such a designation. If the claimant is unable to complete the Plan's written statement, the Plan requires written proof such as a legal power of attorney for health care purposes, or a court order of guardianship or conservatorship showing that the representative has been authorized to act on the claimant's behalf. If another person claims to be representing the claimant in his appeal, the Review Panel has the right to require that the claimant give the Plan a signed statement, advising the Review Panel that he has authorized that person to act on his behalf regarding his appeal. Any representation by another person will be at the claimant's expense.
- (f) Appeals may only be initiated by the claimant (Employee or spouse) or the claimant's authorized representative who has been designated in accordance with subsection (e) above. Appeals will not be accepted from other persons or entities, including providers who are not duly designated authorized representatives.
- (g) The claimant (and his authorized representative, if any) may request to appear in person before the Review Panel. If the Trustees grant his re-

quest, the claimant and his representative's appearance must be at the claimant's expense. Any hearing before the Review Panel to which a claimant or his representative is invited shall be conducted in an informal manner, and no Review Panel proceeding shall be recorded, electronically or stenographically.

- (h) The claimant or his authorized representative may review pertinent documents and may submit comments and relevant information in writing. Upon written request, the Administrative Manager will provide reasonable access to, and copies of, all documents, records or other information relevant to the claim. The Administrative Manager will not charge for copies of documents requested by the claimant in connection with an appeal.
- (i) If the claims office obtained an opinion from a medical or vocational expert in connection with the claim, the Administrative Manager will, on written request, provide the claimant with the name of that expert.
- (j) In deciding the appeal, the Review Panel will consider all comments and documents that are submitted, regardless of whether that information was available at the time of the original claim denial. The review will not defer to the initial denial, and will take into account all comments, documents, records and other information submitted, without regard to whether such information was previously submitted or relied upon in the initial determination.
- (k) If an appeal involves a medical judgment, such as whether treatment is Medically Necessary, the Review Panel will consult with a medical professional who is qualified to offer an opinion on the issue. If a medical professional was consulted in connection with the original claim denial, the Review Panel will not consult with the same medical professional (or a subordinate of that person) for purposes of the appeal.
- (l) If the appeal is for an urgent care claim, the claimant will be notified of the decision about the appeal as soon as possible, taking into account the circumstances, but not later than 72 hours after receipt of the request for review. In the case of non-urgent pre-service claims, the claimant will be notified no later than 30 days after receipt of the request for review.
- (m) A review and determination for disability and post-service claims will be made no later than the date of the meeting of the Trustees that immediately follows the Plan's receipt of a request for review, unless special circumstances exist requiring an extension of time, in which event the

decision shall be rendered not later than 120 days from the date of receipt of the written request for Review by the Administrative Manager. The claimant will be informed of the Trustees' decision, normally within five calendar days of the review.

- (n) Claim appeal decisions will be in writing unless the appeal was for an urgent care claim and the claimant was advised by telephone or fax. When the claimant receives the written decision, it will contain the reasons for the decision and specific references to the particular Plan provisions upon which the decision was based. It will also contain a statement explaining that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim, and a statement of the claimant's right to bring an action under Section 502(a) of ERISA. If applicable, the claimant will also be informed of his right to receive free of charge upon request the specific internal rule, guideline, protocol or similar criterion relied on to make the decision. If the decision was based on a medical judgment, the claimant will receive an explanation of that determination or a statement that such explanation will be provided free of charge upon request.
- (o) While the Plan may not automatically extend the time period for an appeal determination, the time may be extended if the claimant agrees in advance to an extension.
- (p) If the Fund fails to make timely decisions or otherwise fails to comply with the applicable federal regulations, the claimant may go to court to enforce his rights. The claimant may not file suit against the Fund until he has exhausted all of the procedures described in these procedures.

**Section 12. General Rules Governing Payment of Claims.**

- (a) The Trustees, in their discretion, may make payments of claims directly to the provider or to the Employee (or Retiree).
- (b) Loss of life benefits, if any, will be paid in accordance with the provisions, which apply, to such benefits. Any other benefits accrued but unpaid at death may be paid to the deceased person's estate or, at the Trustees' option, to the beneficiary. If any beneficiary has assigned expenses in connection with the burial of the Employee, the Trustees, at their discretion, may reimburse the provider of funeral services, up to the applicable Maximum Benefit. In that event, the beneficiary will be entitled to receive only the remainder, if any, of the proceeds.

- (c) Benefits which are payable to a deceased person's estate or to a person who is a minor or who is not competent to give a valid release may instead be paid at the Trustees' option to any person who is related by blood or marriage and whom the Trustees deem to be suitable to receive them. Such payment will fully discharge the Plan to the extent of the payment.

**Section 13. Physical Examination.**

The Plan reserves the right to have the Participant examined by medical personnel selected by the Trustees as often as the Trustees deem necessary while a claim is pending.

**Section 14. Gender.**

Except as the context may otherwise specifically require, use of the masculine gender shall be understood to include both masculine and feminine genders.

**Section 15. Maximum Amount.**

For any Participant, whether or not there has been an interruption in the continuity of his coverage, the maximum amount of benefits available at any time shall be equal to the maximum amount less the sum of the benefits previously payable on his account.

**Section 16. Severability Clause.**

If any provision of the Plan or any amendment made to the Plan is determined or judged to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions or the Plan.

**Section 17. Protected Health Information.**

- (a) The Fund will use and disclose protected health information (individually identifiable health information, regardless of the form in which it is kept) only to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information. The Fund will not disclose protected health information to the Plan Sponsor, the Board of Trustees of the Midwest Operating Engineers Welfare Fund, or permit a health insurance issuer or HMO to disclose protected health information unless this disclosure

complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information.

- (b) The Fund may disclose to the Board of Trustees “summary health information” (information which summarizes claims history, claims expenses, or types of claims experienced by individuals for whom the Trustees provide coverage under the Fund and from which aspects permitting identification, other than a five digit zip code, have been eliminated) and this information may be used by the Board of Trustees to obtain premium bids from health plans for providing health insurance coverage under the Fund or for the Board of Trustees to modify, amend or terminate this Plan.
- (c) The Fund may disclose to the Board of Trustees protected health information concerning whether a person participates in the Fund or have enrolled or disenrolled from a health insurance issuer, or in the event the Fund were ever to have such options, an HMO.
- (d) The Fund may disclose protected health information to the Board of Trustees pursuant to a written authorization supplied by the Participant or Beneficiary which complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information.
- (e) Except for the disclosures set forth in subsections (b) through (d) above, in order for the Fund to disclose protected health information to the Board of Trustees or to permit the disclosure of such information to the Board of Trustees by a health insurance issuer or HMO with respect to the Fund, for any purposes including the administration of the Fund, the Fund must ensure that the plan documents restrict uses and disclosure of protected health information consistent with the requirements of the Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information. These restrictions are set forth in this Section.
- (f) In order for the Fund to disclose protected health information to the Board of Trustees other than as set forth in subsections (b) through (d) above, the Board of Trustees must certify that the Plan has been amended to incorporate the provisions set forth in this subsection (f) and that the Board of Trustees agrees to each of the items set forth in this subsection (f). Specifically, the Board of Trustees agrees that it will:

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- (i) Not use or further disclose protected health information other than as permitted or required by the plan documents or as required by law;
- (ii) Ensure that any agents, including a subcontractor, to whom the Board of Trustees provides protected health information received from the Fund agree to the same restrictions and conditions that apply to the Board of Trustees with respect to the protected health information;
- (iii) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees;
- (iv) Report to the Fund any use or disclosure of the protected health information that is inconsistent with the uses or disclosure provided for of which it becomes aware;
- (v) Make available protected health information as required by the Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information;
- (vi) Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information;
- (vii) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Fund available to the Secretary of Health and Human Services for purposes of determining compliance by the Fund with Subpart E of the Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information; and
- (viii) If feasible, return or destroy all protected health information received from the Fund that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible and provide for the separation of the Fund and Board of Trustees and protections set forth in subsection (g) below.

- (g) The Board of Trustees shall ensure that adequate separation exists between the Fund and the Board of Trustees. In order to ensure this separation:
  - (i) Access to protected health information provided from the Fund to the Board of Trustees shall be restricted to the members of the Board of Trustees who are involved in matters relating to payment, health care operations or other matters pertaining to the Fund in the ordinary course of business;
  - (ii) Access by the Trustees to protected health information provided from the Fund to the Board of Trustees shall be restricted to the plan administration functions that the Board of Trustees provide for the Fund; and
  - (iii) The Board of Trustees shall provide an effective mechanism for resolving any issues of noncompliance by Trustees with the provisions of this Section.
- (h) The Fund may not disclose protected health information to the Board of Trustees nor permit a health insurance issuer or HMO to disclose protected health information to the Board of Trustees as otherwise permitted under the Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information unless a statement required by Section 164.520(b)(1)(iii)(C) of these Regulations is included in the Notice of Privacy Practices promulgated under Section 164.520.
- (i) The Fund may not disclose protected health information to the Board of Trustees for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees.

## **ARTICLE 5 – CASE MANAGEMENT**

### **Section 1. General.**

Case Management is provided to assist a Participant in benefit conservation and treatment alternatives. Pre-certification by the Case Manager or Administrative Manager is required in order for Participants to receive reimbursement for certain expenses to the full extent provided in the Plan.

Pre-certification decisions are limited to whether expenses are covered for reimbursement under the Plan. Pre-certification does not constitute medical advice to the Participant. Regardless of whether a particular expense is covered under the Plan, the Participant remains free to decide, in consultation with the Physician of his choice, whether to undergo such treatment, and pre-certification is not intended to interfere (and shall not be construed as interfering) with the Physician-patient relationship.

### **Section 2. Pre-Certification Requirements**

The Participant must contact the Case Manager whenever one of the following types of service or care is recommended or anticipated. If the Participant fails to obtain pre-certification from the Case Manager no benefits will be payable for that service or care.

- (a) transplant surgery;
- (b) outpatient physical therapy;
- (c) Continuing Care;
- (d) treatment for Mental or Nervous Disorders or Substance Abuse (requires pre-certification by the MAP);
- (e) outpatient physical, occupational and speech therapy for congenital neurological diseases for Dependent children;
- (f) durable medical equipment;
- (g) treatment for temporomandibular joint dysfunction (TMJ);
- (h) cochlear implants and auditory brainstem implants;

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- (i) Skilled Nursing Facility care; and
- (j) Home Health Care.

## **ARTICLE 6– EMPLOYEE DEATH BENEFIT**

### **Section 1. General.**

A Death Benefit is payable upon the death of an Eligible Employee in a Benefit Plan that includes Employee Death Benefits. Upon receipt of written proof of the death of the Employee, the Plan shall pay the Death Benefit amount specified on the Participant's Schedule of Benefits.

### **Section 2. Beneficiary.**

- (a) Any sum becoming due by reason of the death of an Eligible Employee is payable to the beneficiary named on the Plan's records in accordance with the Employee's election, or as provided in this Article.
- (b) If more than one beneficiary is named and the Employee fails to specify their respective interests, the beneficiaries will share the Benefit equally.
- (c) If any named beneficiary dies before the Employee, his interest will end and his share will be payable equally to such other named beneficiaries as survive the Employee, unless the Employee has made a written direction to the contrary.
- (d) In the event no named beneficiary survives the Employee or no beneficiary was named by the Employee, the amount due under this Benefit will be payable as follows:
  - (i) to the Employee's spouse, if living, or if not living; then
  - (ii) to the Employee's children in equal shares, or if none survive; then
  - (iii) to the Employee's father and mother, equally if both survive, or all to the survivor of them if only one survives the Employee, or if none survives; then
  - (iv) to the Employee's estate.

### **Section 3. Change of Beneficiary.**

An Employee may, from time to time, name a new beneficiary by filing a written designation on a form satisfactory to the Trustees. The change will take effect as

of the date the change of beneficiary designation is received by the Fund Office, provided, however that no change in beneficiary will be effective if the Trustees have already acted upon reliance of a prior designation.

**Section 4. Facility of Payment.**

If any beneficiary has assigned expenses in connection with the burial of the Employee, the Trustees, at their discretion, may reimburse the provider of funeral services, up to the applicable Maximum Benefit. In that event, the beneficiary will be entitled to receive only the remainder, if any, of the proceeds.

## ARTICLE 7 – EMPLOYEE ACCIDENTAL DISMEMBERMENT BENEFIT

### Section 1. General.

Benefits will be paid as specified on the Participant's Schedule of Benefits and in this Article if an Eligible Employee, in a Benefit Plan that includes Employee Accidental Dismemberment Benefits, suffers an injury which results in any losses described in Section 2 below, upon presentation of a proper claim.

### Section 2. Benefits Payable.

The amount of the benefit payable to the Eligible Employee as follows:

LOSS	BENEFIT
Loss of one hand or one foot or the sight of one eye .....	\$5,000
Loss of one finger, including thumb .....	\$1,000

Loss of a hand or foot means severance at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. Loss of a finger means complete severance of a finger down to at least the first joint. The loss of all five fingers shall constitute the loss of a hand, even though there is no severance at or above the wrist.

If an Eligible Employee suffers more than one of the losses described above as a result of any one accident, no more than \$10,000 shall be payable.

## ARTICLE 8 – DEPENDENT DEATH BENEFIT

### Section 1. General.

A Death Benefit is payable upon the death of an Eligible Dependent of an Eligible Employee in a Benefit Plan that includes Dependent Death Benefits. Upon receipt of written proof of the death of the Dependent, the Plan shall pay the Dependent Death Benefit amount specified on the Participant's Schedule of Benefits.

### Section 2. Beneficiary.

#### **(a) Death of Eligible Dependent Spouse**

- (i) Any sum becoming due by reason of the death of an Dependent spouse is payable to the Employee, if living.
- (ii) In the event the Employee does not survive the spouse, the amount due under this Benefit will be payable to the spouse's estate.

#### **(b) Death of Eligible Dependent Child**

- (i) Any sum becoming due by reason of the death of an Dependent child is payable to the Employee, if living.
- (ii) In the event the Employee does not survive the child, the amount due under this Benefit will be payable as follows:
  - (A) to the Employee's spouse, if living, or if not living; then
  - (B) to the Dependent child's estate.

### Section 3. Facility of Payment.

If any beneficiary has assigned expenses in connection with the burial of the Dependent, the Trustees, at their discretion, may reimburse the provider of funeral services for the amount paid, up to the applicable Maximum Benefit. In that event, the beneficiary will be entitled to receive only the remainder, if any, of the proceeds.

## ARTICLE 9 – WEEKLY DISABILITY BENEFIT

### Section 1. General.

A Weekly Disability Benefit is payable upon the Disability of an Eligible Employee in a Benefit Plan that includes Weekly Disability Benefits. Upon written receipt of proof that the Employee has become Totally Disabled as a result of a non-Work-Related Illness or Injury, or a Work-Related Illness or Injury as provided for under Article 16, Subrogation, and requires the regular care of a Physician (M.D. or D.O.) which shall be determined according to the condition for which the Eligible Employee is being treated, the Employee shall receive a weekly benefit, subject to the provisions of this Article.

### Section 2. Benefits Payable.

- (a) The weekly benefit shall be payable in the amount set forth on the Employee's Schedule of Benefits, less any amounts payable to the Eligible Employee from any of the following:
  - (i) a wage continuation program available through the Contributing Employer; or
  - (ii) a group insurance plan, government plan, or another employee welfare plan.
- (b) Benefits are payable after completion of the waiting period, which is seven days of Disability. The first benefit payment will include all days of Disability from the first day of Disability. Benefits are payable for up to 52 weeks per period of Disability. The weekly benefit shall terminate immediately if the Eligible Employee is on an out-of-work list (either light duty or any other out-of-work list maintained by the Union).
- (c) During partial weeks of Disability, the Eligible Employee shall be paid a daily rate of one-seventh of the weekly benefit amount set forth on the Participant's Schedule of Benefits.
- (d) Successive periods of Disability due to Injuries received in an accident will be considered one period of Disability. A period of Disability that results from both an Injury and an Illness will be considered one period of Disability.

**Section 3. Periods of Disability.**

Successive periods of Disability shall be considered one period of Disability unless the Eligible Employee has either returned to or is available for active work for at least one day between the disabilities.

**Section 4. Exclusions and Limitations.**

No benefits shall be payable under this Article for any:

- (a) Disability resulting from Illness or Injury for which an Eligible Employee is not under the care of a Physician (M.D. or D.O.), or any period for which the Physician has not certified the Employee's Total Disability;
- (b) Disability that begins while the Employee is not actively working for a Contributing Employer;
- (c) Disability for which the Employee has a right to payment under any Workers' Compensation law or occupation disease law;
- (d) Period of time for which the Employee is receiving Disability pension benefits;
- (e) Disability due to a Work-Related Illness or Injury, except as provided for under Article 16, Subrogation; or
- (f) Disability resulting from a loss, problem, complaint, pain or ailment which did not arise from an objectively determined and documented medical impairment.

## **ARTICLE 10 – COMPREHENSIVE MEDICAL EXPENSE BENEFIT**

### **Section 1. General.**

If a Participant who is eligible for Comprehensive Medical Expense Benefits incurs Covered Expenses as a result of a non-Work-Related Illness or Injury or a Work-Related Illness or Injury as provided for under Article 16, Subrogation, payment will be made for the charges incurred, up to the maximum amounts specified on the Participant's Schedule of Benefits and according to the provisions of this Article.

### **Section 2. PPO Agreement.**

The Fund has entered into agreements with Preferred Provider Organizations (PPOs). Participants may choose health care services provided by Physicians, Hospitals and Health Care Providers who have negotiated service agreements with the PPOs. The Plan generally pays a higher percentage when PPO providers are used.

### **Section 3. Benefits Payable.**

Benefits are payable at the percentage specified on the Participant's Schedule of Benefits for Covered Expenses after any applicable deductible has been satisfied.

Benefits payable under this Article shall not exceed the maximums specified on the Participant's Schedule of Benefits.

### **Section 4. Deductible Amounts.**

- (a) The Calendar Year Deductible is the amount of Covered Expenses the Participant pays before he is entitled to certain Comprehensive Medical Benefits.
- (b) The Calendar Year Deductible applies only once in any Calendar Year though the Participant may have several different disabilities. However, any Covered Expense applied against a Participant's Calendar Year Deductible in the last three Months of a Calendar Year may also be applied against the Participant's Calendar Year Deductible for the next Calendar Year.

- (c) When a family has satisfied the Calendar Year family deductible, as specified on the Participant's Schedule of Benefits, no further deductible will be required for Covered Expenses incurred thereafter in that Calendar Year for any family members. The last-quarter carry-over rule set forth in subsection (b) above is applicable to individual deductibles only, not to family deductibles.

**Section 5. Out-of-Pocket Maximum.**

- (a) During a Calendar Year, once a Participant has reached the amount of the Out-of-Pocket Maximum specified on his Schedule of Benefits (which includes satisfaction of the Calendar Year Deductible and the Participant's applicable percentage share of incurred Covered Expenses), the Plan shall pay, subject to all applicable limitations and provisions, 100% of all of the Covered Expenses which are incurred by that Participant for the remainder of that Calendar Year, subject to the exclusions specified in the subsection (b) below.
- (b) Out-of-pocket expenses payable by Participant for the following shall not apply toward satisfaction of the Out-of-Pocket Maximum:
  - (i) amounts paid for Covered Expenses which are reimbursed by the Plan at 50%;
  - (ii) amounts that exceed Reasonable and Customary Charges;
  - (iii) charges for expenses not covered by the Plan; and
  - (iv) charges covered under the Family Supplemental Benefit.

**Section 6. Maximum Benefit.**

The overall Maximum Benefit payable under this Article for all Covered Expenses incurred by a Participant due to all Injuries or Illnesses in a Calendar Year is specified on the Participant's Schedule of Benefits. Whenever, during a Calendar Year, Covered Expenses exceed the overall maximum, the Plan will pay additional benefits, up to the Supplemental Lifetime amount shown on that Schedule of Benefits. The Supplemental Benefit amount is totaled over the lifetime of the Participant, whether or not there has been an interruption in the continuity of eligibility for benefits under the Plan.

**Section 7. Pre-Existing Conditions.**

- (a) Payment for a Participant's Covered Expenses, including covered prescription drugs, incurred for a Pre-Existing Condition will be made up to

a maximum of \$15,000, during the twelve-month period that begins with the individual's Enrollment Date, provided, however, that this twelve-month period shall be reduced by the number of days of prior creditable coverage the affected individual has as of his Enrollment Date.

- (b) "Creditable coverage," as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), generally means health care coverage provided by a group, individual or public health plan. The affected individual is required to demonstrate his prior creditable coverage by presenting a written certification of health coverage as provided to him by the plan providing the coverage, or if the individual did not receive a certificate, the individual has a right to demonstrate creditable coverage through the presentation of documentation or other means. Days of creditable coverage that occur before a Break in Coverage will not be used to reduce the length of an individual's Pre-Existing Condition limitation period.
- (c) The Pre-Existing Condition limitation shall not apply to Pregnancy. In addition, a Pre-existing Condition limitation period shall not be applied to a newborn, an adopted child under age 18 or a child placed for adoption under age 18, provided that any such child becomes covered under the Plan within 30 days of birth, adoption or placement for adoption.

*Section 7(c)  
amended effective  
January 1, 2011  
(see Amendment  
No. 16).*

### **Section 8. Covered Expenses.**

Except as otherwise provided in Section 9 of this Article and in Article 18, Covered Expenses under this Comprehensive Medical Expense Benefit are the actual Reasonable and Customary Charges incurred for the services and supplies listed below:

- (a) **Hospital** expenses as follows:
  - (i) Hospital room and board charges up to the standard daily rate for a semi-private room;
  - (ii) Hospital room and board charges up to the standard daily rate for a private room when confined due to contagious disease;
  - (iii) Charges for specialty care units (e.g. intensive care, cardiac care unit) up to the standard daily rate for such unit;
  - (iv) Other services and supplies furnished by a Hospital;
  - (v) Emergency room charges; and

- (vi) Implants, provided that the invoice from the supplier is submitted.
- (b) **Physicians'** professional medical and surgical services as follows:
  - (i) Hospital, office and home visits;
  - (ii) Emergency room services;
  - (iii) Services for surgical procedures.
- (c) **Nursing services** provided by a registered nurse.
- (d) **Surgical supplies**, surgical dressings, casts, splints, trusses, braces, and crutches.
- (e) **Anesthetics** and their administration, blood and blood plasma and its administration, oxygen and the rental of equipment for the administration of oxygen.
- (f) **X-ray and laboratory** examinations and x-ray, radium and radioactive isotope therapy.
- (g) **Pre-admission testing** which meets the following conditions:
  - (i) the tests are related to the condition for which the person will be hospitalized;
  - (ii) the tests must be accepted and not duplicated by the admitting Hospital; and
  - (iii) the Hospital admission must begin within 14 days after the tests are performed.
- (h) **Second and third surgical opinions** from a Board Certified Surgeon.
- (i) **Chemotherapy drugs and supplies** administered under the direction of a Physician.
- (j) **Hemodialysis** or peritoneal dialysis and supplies administered under the direction of a Physician including x-ray and laboratory examinations.
- (k) **Skilled Nursing Facility** confinement that meets the following conditions:
  - (i) is recommended and supervised by a Physician, and

*Section 8(i)  
amended effective  
January 1, 2011  
(see Amendment  
No. 14).*

(ii) begins within 30 days of a Hospital confinement due to the same cause. Payment will be limited to 45 days per period of confinement. Successive confinements will be considered one period of confinement unless the patient returns to work for one full day before the second confinement, or the confinements are separated by 30 days with no treatment.

- (l) **Hospice Care** by a licensed Hospice, including Respite Care.
- (m) **Home Health Care** services provided by a Home Health Care Agency, provided that the plan of care is pre-certified as Medically Necessary by the Case Manager, and:
- (i) is prescribed by a Physician (M.D. or D.O.); and
  - (ii) is reviewed and approved by the Physician (M.D. or D.O.) during the entire period.

Benefits are subject to any applicable maximum or limitation specified on the Participant's Schedule of Benefits.

- (n) **Take-home drugs** or medicines and prescription drugs used to treat cancer.
- (o) **Newborn and well child** outpatient and office visits and routine childhood immunizations for a Dependent child from birth through age 24 months. Payment is limited to the amount specified on the Participant's Schedule of Benefits.

*Section 8(o)  
amended effective  
January 1, 2011  
(see Amendment  
No. 8).*

- (p) **Repair of accidental Injuries to oral/facial structures** including, but not limited to jaw and facial bone fractures and sound natural teeth, provided the service is rendered within twelve months of the accident.

*Section 8(p)  
amended effective  
January 1, 2008  
(see Amendment  
No. 8).*

- (q) **Allergy medications** and their administration.
- (r) **Preventive care** for Employees, Retirees and Dependent spouses, as follows, but only if preventive care is a Covered Expense on the Participant's Schedule of Benefits:
- (i) Physician's charges for a routine annual physical examination;
  - (ii) mammogram;
  - (iii) hearing examination provided by a Physician or licensed audiologist;
  - (iv) employment physical;

- (v) immunizations; and
- (vii) influenza shots.
- (s) **Medical transportation** services, as follows:
  - (i) Medically Necessary ground or air ambulance transportation by a professional ambulance service from the site where the Injury, medical emergency or acute illness occurs to the nearest appropriate facility; or
  - (ii) inter-health-care-facility transfer to the nearest appropriate facility for the treatment of a medical emergency, subject to the following. The maximum allowable expense for an inter-facility transport will be \$5,000. The \$5,000 limit will not apply if the Case Manager determines that the additional charges are Medically Necessary and that no less-costly form of transport would have been appropriate due to the patient's health status.
- (t) **Durable medical equipment** which meets all of the following:
  - (i) it is for repeated use and is not a consumable or disposable item;
  - (ii) it is used primarily for a medical purpose; and
  - (iii) it is appropriate for use in the home.

The Case Manager must pre-certify the rental or purchase of equipment costing more than \$250. Failure to pre-certify will result in a benefits reduction if such a reduction is included on the Participant's Schedule of Benefits. In addition, no benefits will be paid if the equipment is not determined by the Case Manager or Administrative Manager to be Medically Necessary.

Rental of durable medical equipment is covered up to the purchase price of the equipment.

- (u) **Orthoptic training** in lieu of surgery for Dependent children under age 10. Payment will be limited to a maximum of 40 visits per lifetime.
- (v) **Prosthetic and support devices**, including colostomy or ostomy supplies. Payment for foot orthotics will be made only when prescribed by a Physician (M.D. or D.O.) or podiatrist and custom-fitted, and only up to the limits specified on the Participant's Schedule of Benefits.
- (w) **Rehabilitation occupational therapy** performed on an outpatient basis due to an Injury or Illness, including but not limited to:

*Section 8(t)  
amended effective  
June 1, 2009 (see  
Amendment  
No. 12).*

- (i) stroke;
- (ii) brain tumor;
- (iii) brain trauma; or
- (iv) heart attack.

(x) **Physical therapy** performed on an outpatient basis for an Illness or Injury when deemed Medically Necessary by the Case Manager or Administrative Manager.

*Section 8(y)  
amended effective  
January 1, 2008  
(see Amendment  
No. 1).*

(y) **Physical and occupational therapy for congenital neurological diseases for dependent children through age 18 only**, up to the maximum benefit specified on the Participant's Schedule of Benefits. Congenital neurological diseases include cerebral palsy muscular dystrophy, Down's Syndrome and Edward's Syndrome.

(z) **Restorative speech therapy** for adults and children performed on an outpatient basis, when Medically Necessary to restore speech that was lost or impaired as a result of an Illness or Injury.

(aa) **Developmental speech therapy for children**, including therapy for congenital neurological disorders and pervasive developmental disorders, up to the limits specified on the Participant's Schedule of Benefits. These services are covered only when deemed Medically Necessary by the Case Manager.

(bb) **MRIs (magnetic resonance imaging) and CT (computerized tomography) scans.**

(cc) **Orthodontic** treatment of TMJ and other jaw disorders, subject to the limits for TMJ specified on the Participant's Schedule of Benefits. The treatment must be pre-certified by the Case Manager.

(dd) **Pregnancy** as follows:

- (i) The Plan will provide Maternity benefits for the mother and her newborn infant for at least 48 hours of inpatient Hospital care following a normal delivery and at least 96 hours of inpatient Hospital care following a Caesarean section. The Plan shall not require pre-certification for a length of stay not in excess of these periods. (The attending provider may, however, after consultation with the mother, discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a Caesarean sec-

tion.) Maternity care will be paid the same as any other covered illness.

- (ii) Home delivery is covered when the attending Physician is an M.D.
- (ii) Termination of Pregnancy is covered once in a twelve-month period. Evidence of Medical Necessity must be provided for termination of a Pregnancy in the second or third trimester.

- (ee) **Continuing Care**, when approved by the Case Manager or Administrative Manager.
- (ff) **Cochlear implants** and auditory brainstem implants that have been pre-certified to be Medically Necessary by the Case Manager.

Benefits are subject to any applicable maximum or limitation specified on the Participant's Schedule of Benefits.

- (gg) **Chiropractic care** but only for spinal manipulations and x-rays up to the maximum benefits specified on the Participant's Schedule of Benefits. Chiropractic services for a child under age 5 are not covered.
- (hh) **Intrauterine devices (IUDs), Norplant and Depo-Provera injections.**

*Section 8 amended by addition of Paragraphs (ii) through (mm): See Amendment No. 2 (effective August 1, 2008), Amendment No. 3 (effective January 1, 2009), Amendment No. 12 (effective June 1, 2009), and Amendment No. 13 (effective May 1, 2009).*

### **Section 9. Exclusions and Limitations.**

No benefits shall be payable under this Article for any of the following:

- (a) Illness or Injury that is related to any occupation or employment for wages or profit.
- (b) Care and treatment that is not Medically Necessary, except as specified under this Article 10.
- (c) Expenses specified as not payable in Article 18, General Plan Exclusions and Limitations.
- (d) Cosmetic Surgery or Treatment, except for treatment of an accidental Injury or for a congenital anomaly in Dependent children. Surgery or treatment for complications arising for non-covered Cosmetic Surgery or Treatment is also excluded.
- (e) Reconstructive surgery, except for the following:

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- (i) when performed to improve the function of a body part when the malfunction is the direct result of congenital defect, developmental abnormality, infection, tumor, disease or trauma;
  - (ii) when performed to remove scar tissue on the neck, face or head; and
  - (iii) breast surgery following a mastectomy including surgery and reconstruction of the other breast to produce a symmetrical appearance.
- (f) Reversal of sterilization, hormone therapy, artificial insemination, in vitro fertilization, GIFT, ZIFT, or any other direct attempt to induce or facilitate fertility or conception, with the exception of services and supplies for the diagnosis of Infertility.
- (g) Vocational therapy.
- (h) Routine foot care such as removal of corns or calluses, the cutting and trimming of toenails, foot care for flat feet, fallen arches and chronic foot strain.
- (i) Immunizations, routine physical examinations, or physical examinations or medical certificates required for employment, except as set forth in Section 8 of this Article 10.
- (j) Radial keratotomy (RK), photo refractive keratectomy (PRK), laser in situ keratomileusis (LASIK) or other procedures for surgical or laser correction of myopia and/or other refractive errors.
- (k) The purchase, servicing, fitting and/or repair of hearing aid devices.
- (l) Diagnosis and treatment of refractive lenses, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies.
- (m) Personal convenience or comfort items including, but not limited to, such items as televisions, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.
- (n) Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment would otherwise qualify as a Covered Expense and the provider of the service meets the definition of a Physician, Hospital or Health Care Provider.
- (o) Any operation or treatment for teeth and gums, except:

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- (i) tumors;
  - (ii) removal of a cyst certified by a Physician or Dentist to be Medically Necessary to be performed in a Hospital or freestanding surgical facility that has been pre-authorized by the Fund Office;
  - (iii) orthodontia, as set forth in Item (cc) of Section 8 of this Article 10; or
  - (iv) repair of Injury to sound natural teeth which occurs within twelve months of the accident.
- (p) Chelation therapy, except in cases of heavy metal poisoning.
- (q) Any expenses that are not Covered Expenses.
- (r) Telephone consultations.
- (s) Weight loss programs such as Jenny Craig, Nutri-Systems, etc., including nutritional counseling.
- (t) More than one surgical procedure for obesity per lifetime.
- (u) Treatment for Substance Abuse or Mental or Nervous Disorders except as provided under Article 11.
- (v) Wigs or toupees, hair transplants, hair weaving or any drug in connection with baldness.
- (w) Medical, surgical, psychiatric or prescription drug treatment related to transsexual (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.
- (x) Services rendered by athletic trainers, kinesiologists, massage therapists, recreational therapists, therapy aides/assistants or any other non-therapist professionals, even if a covered provider is supervising the therapy or billing for the treatment.
- (y) Transplants except ligaments and tendons (see Article XII).
- (z) Genetic testing.

## **ARTICLE 11 – MENTAL HEALTH BENEFITS**

### **Section 1. General.**

- (a) The Trustees have contracted with a mental health care management organization to provide a MAP (Member Assistance Program) for Plan Participants. If a Participant requires treatment for a Mental or Nervous Disorder or Substance Abuse, pre-approval must be obtained by contacting the MAP before the treatment begins.
- (b) Benefits for the all treatment Mental or Nervous Disorders and Substance Abuse are payable only under this Article, except that prescription drugs which are payable under Article 13,

### **Section 2. Benefits Payable.**

- (a) Benefits for treatment of Mental or Nervous Disorders or Substance Abuse are payable subject to the payment provisions and special limitations specified on the Participant's Schedule of Benefits, but only if the treatment is pre-certified by the MAP and the treatment is provided by a network provider.
- (b) Benefits paid by the Plan for Covered Expenses for treatment of Mental or Nervous Disorders or Substance Abuse apply to the Participant's Maximum Benefits under the Comprehensive Medical Expense Benefit.
- (c) If a covered person fails to obtain pre-certification or to utilize a network provider, no benefits will be payable.
- (d) Benefits can include payments to providers who are Health Care Providers as defined in Section 2(25), when recommended and approved by the MAP.

### **Section 3. Exclusions and Limitations.**

No benefits shall be payable under this Article for:

- (a) any expenses that are not Covered Expenses under the provisions of the Comprehensive Medical Expense Benefit;
- (b) care or treatment that has not been approved by the MAP;

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- (c) care and treatment that is not Medically Necessary; or
- (d) expenses specified as not payable in Article 18, General Plan Exclusions and Limitations.

## **ARTICLE 12 – TRANSPLANT BENEFITS**

### **Section 1. General.**

- (a) This Article provides a human organ and tissue transplant benefit to Eligible Participants. The benefits described in this Article 12 do not apply to Eligible Participants and Dependents who are eligible for Medicare and do not use Medicare-approved providers.
- (b) Benefits are only payable when the procedure is pre-certified through Case Management and this Plan's network providers are utilized. A Medicare-eligible Eligible Participant or Dependent must use a Medicare-approved provider.
- (c) Benefits for human organ and tissue transplants are only provided under this Article 12.

### **Section 2. Covered Transplant Procedures.**

Covered transplant procedures are limited to the following non-Experimental human to human organ or tissue transplants: bone marrow (self- and other-donated); heart; heart/lung; liver; lung; kidney and cornea. No other transplants are covered.

### **Section 3. Covered Services.**

Covered services include the following:

- (a) organ and tissue procurement, including Medically Necessary costs incurred by a donor if such costs are not covered under another plan;
- (b) transportation, lodging and meal costs for the recipient and a companion or two companions if the recipient is a minor;
- (c) Hospital, room and board, and medical supplies;
- (d) diagnosis, treatment, and surgical procedures performed by a Medical Doctor (M.D.);
- (e) private nursing care by an R.N. or L.P.N.;

- (f) rental of wheelchair, hospital-type beds, and respiratory therapy equipment;
- (g) local ambulance services;
- (h) medications;
- (i) X-rays and other diagnostic services, laboratory tests, and oxygen; and
- (j) Surgical dressings and supplies.

**Section 4. Benefit Period.**

The benefit period begins five days (30 days before for bone marrow) before the date of the organ or tissue transplant and ends 18 months after the transplant procedure. Multiple transplant procedures will be covered under the same or separate benefit periods as follows:

- (a) If they are due to related causes, they will be covered in the same benefit period.
- (b) If the transplants are due to unrelated causes, they will be covered under separate benefit periods.
- (c) If they are due to related causes, they are covered under separate benefit periods if an Eligible Participant returns to active work before the second transplant, or if a Dependent's transplants are separated by at least three consecutive months.

**Section 5. Benefits Payable.**

- (a) Benefits for covered transplant procedures are payable subject to the payment provisions specified on the Participant's Schedule of Benefits.
- (b) Plan benefits will not exceed the aggregate lifetime amount specified on the Participant's Schedule of Benefits for all covered services during a benefit period. Within this aggregate lifetime maximum, the following aggregate limits apply:
  - (i) a \$25,000 limit on organ or tissue procurement;
  - (ii) a \$10,000 limit for transportation and lodging; and
  - (iii) a \$10,000 limit for private duty nursing care.

*Section 5(b)  
amended effective  
January 1, 2011  
(see Amendment  
No. 17).*

- (c) Benefits paid by the Plan for a covered transplant procedure do not apply to the Participant's Maximum Benefit under the Comprehensive Medical Expense Benefit.

**Section 6. Exclusions and Limitations.**

No benefits shall be payable under this Article for:

- (a) services that are not pre-certified through Case Management;
- (b) services not provided by a provider in this Plan's provider network, or if the Participant or Dependent is eligible for Medicare, service not provided by a Medicare-approved provider;
- (c) charges which exceed the transplant maximum benefits specified on the Participant's Schedule of Benefits and under Section 5 of this Article 12;
- (d) transplants which are not listed in Section 2 of this Article 12;
- (e) treatment or medication which is Experimental or Investigational; or
- (f) expenses specified as not payable in Article 18, General Plan Exclusions and Limitations.

## **ARTICLE 13 – PRESCRIPTION DRUG PROGRAM**

### **Section 1. General.**

- (a) If a Participant incurs Covered Expenses for Prescription Drugs as a result of an Illness or Injury, payment will be made for the charges incurred, up to the maximum amounts specified on the Participant's Schedule of Benefits and according to the provisions of this Article 13.
- (b) The Prescription Drug Program consists of two programs: the Midwest Benefit Pharmacy Program and the Pharmacy Benefit Manager Program for emergency medications. A Participant is only entitled to use the Pharmacy Benefit Manager Program if it is included on the Schedule of Benefits for his Benefit Plan.
- (c) The Prescription Drug Program is separate from the Comprehensive Medical Expense Benefit. Any Co-Pay amounts paid by or on behalf of a Participant under the Prescription Drug Program, do not apply to his or his family's Out-of-Pocket Maximum, and any benefits paid by the Plan under this Article only apply to the annual Prescription Drug Program maximum and do not apply to the individual's Maximum Benefit under the Comprehensive Medical Expense Benefit.
- (d) A Medicare-eligible Participant or Dependent who is enrolled in a Medicare prescription drug (Part D) plan is not eligible to use this Plan's Prescription Drug Program.

### **Section 2. Midwest Benefit Pharmacy Program.**

- (a) Benefits are payable for the full cost of prescriptions, less any applicable Co-Pay specified on the Participant's Schedule of Benefits for Brand Name Drug purchases as described in Section 2(b) of this Article, and for prescriptions filled at the Midwest Benefit Pharmacy.
- (b) When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a Participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions," when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.

- (c) The maximum supply allowable for prescriptions filled at the Midwest Benefits Pharmacy is 90 days. In addition, dispensing limits may apply to certain medications based on the manufacturer's recommended dosage and duration of therapy, common usage, FDA and state recommendations and/or clinical studies, or as determined by the Trustees or the Administrative Manager. For example, the following dispensing limits were in effect as of the effective date of this document:
  - (i) Muse® maximum box of 6;
  - (ii) Caverject® maximum box of 6;
  - (iii) Toradol® limited to a 6-day supply; and
  - (iv) Epipen® and Epipen, Jr.® maximum of 2.

### **Section 3. Pharmacy Benefit Manager Program**

- (a) Benefits are payable only for emergency medical Prescription Drugs filled at a network pharmacy at the percentage specified on the Participant's Schedule of Benefits.
  - (i) A "network pharmacy" is a pharmacy that has an agreement with the Plan's contracted prescription benefit manager.
  - (ii) An "emergency medical drug" is one that is Medically Necessary and not for long-term or maintenance use.
- (b) The maximum supply allowable for emergency medical prescriptions filled at a network pharmacy is 15 days.
- (c) When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a Participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions," when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.

### **Section 4. Maximum Benefit.**

- (a) Aggregate benefits payable under the Prescription Drug Program shall not exceed the annual maximum benefit specified on the Participant's Schedule of Benefits.
- (b) Aggregate benefits payable for the initial Plan-approved twelve-month course of drug therapy for treatment of Hepatitis C shall not exceed the

maximum benefit specified on the Participant's Schedule of Benefits. Any portion of the cost of treatment that exceeds such limit will be subject to the Prescription Drug Program annual maximum benefit.

**Section 5. Covered Prescription Drug Expenses.**

The following supplies, authorized by a Physician, will be considered Covered Expenses under both the Midwest Benefit Pharmacy Program and the Pharmacy Benefit Manager Program:

- (a) Legend drugs, which are lawfully obtainable only from an individual, licensed to dispense drugs upon the prescription of a Physician;
- (b) drugs for the intent of administration by a Physician or R.N.;
- (c) injectable insulin;
- (d) needles and syringes;
- (e) diabetic test strips and lancets, up to a maximum of a 100-unit supply every 30 days; and
- (f) prescription oral, transdermal and injectable contraceptives.

**Section 6. Exclusions and Limitations.**

No benefits shall be payable under the Prescription Drug Program for:

- (a) non-Legend or over-the-counter drugs;
- (b) drugs dispensed for use by the Participant while Hospital confined;
- (c) contraceptive devices that are not specifically stated as covered, such as diaphragms;
- (d) drugs that promote hair growth, including Propecia;
- (e) drugs that are intended to promote fertility, including, but not limited to the following:
  - (i) Serophene;
  - (ii) Clomide;
  - (iii) Profasi;
  - (iv) Metrodin; and

- (v) Pergonal.  
unless prescribed for a medical condition other than infertility;
- (f) non-drug items, including but not limited to vitamins, nutritional supplements, including but not limited to “Optifast” or “Medifast,” and support garments, regardless of intended use;
- (g) non-emergency medical prescriptions filled at any retail pharmacy, emergency medical prescriptions filled at an out-of-network pharmacy, more than a 15-day supply of an emergency medical prescription filled at a network pharmacy;
- (h) more than a 90-day supply of a drug filled at the Midwest Benefits Pharmacy;
- (i) drugs dispensed at a physician’s office, hospital outpatient or other facility;
- (j) Experimental drugs or drugs intended for Experimental or Investigational treatment as determined by the Trustees or when the federal label states “Caution: Limited by federal law to investigation use,” or drugs that are not prescribed or used in a manner consistent with the manufacturer’s and the FDA’s intended and approved usage;
- (k) drugs prescribed for use in connection with sex transformation treatments and procedures;
- (l) drugs prescribed for a cosmetic purpose except, Retin-A and Renova when Medically Necessary;
- (m) drugs prescribed in connection with a procedure that is not covered under this Plan, including but not limited to any complication that arises as a result of a non-covered procedure;
- (n) any drug charges which exceed the Participant’s applicable Prescription Drug Program maximum benefit, except for drugs used in Hepatitis C treatment which are subject to the separate maximum stated on the Schedule of Benefits;
- (o) medicine and drugs that do not require a prescription to purchase;
- (p) any prescription drug purchased under another group health plan; or
- (q) Viagra or any other drugs for the treatment of sexual dysfunction.

## **ARTICLE 14 – DENTAL EXPENSE BENEFIT**

### **Section 1. General.**

- (a) If a Participant in a Benefit Plan that includes Dental Benefits incurs Covered Expenses for Dental Services, payment will be made for the charges incurred, up to the maximum amounts specified on the Participant's Schedule of Benefits and according to the provisions in this Article.
- (b) The Participant must be eligible for Dental Benefits on the date the expense is incurred. The incurral date for a dental prosthetic will be the date the initial impression is taken, and the incurral date for a root canal will be the date the tooth is initially opened.

### **Section 2. DPPO Agreement.**

The Fund has entered into an agreement with a Dental Preferred Provider Organization (DPPO). Employees and Dependents may obtain dental services provided by Dentists who have negotiated service agreements with the DPPO.

### **Section 3. Allowable Charges.**

The Plan pays for Basic and Restorative and Orthodontic services according to the Allowable Charge. Charges in excess of the Allowable Charge are not covered by the Plan, whether or not DPPO providers are used.

- (a) The negotiated fee that a dentist in the DPPO can charge for a service under the terms of the Dentist's agreement with the DPPO is the Allowable Charge for such service.
- (b) If a Participant obtains dental care from a Dentist who does not participate in the DPPO, the Allowable Charge is the scheduled amount a DPPO dentist could charge for the same service. The Participant is responsible for payment of any amount in excess of the Allowable Charge.

### **Section 4. Benefits Payable.**

- (a) Benefits are payable at the percentage specified on the Participant's Schedule of Benefits for Covered Expenses incurred for dental care or treatment.

- (b) Benefits payable under this Article shall not exceed the maximums specified on the Participant's Schedule of Benefits.

**Section 5. Covered Dental Expenses.**

Covered Dental Expenses include the charges for services and supplies listed below which meet all of the following:

- (a) are authorized by a Dentist;
- (b) are of the usual type furnished for the purpose;
- (c) are performed by a Dentist, orthodontist or dental hygienist.
- (d) Covered Preventive Services include:
  - (i) routine oral examinations and prophylaxis (scaling and cleaning of the teeth), but not more often than twice in a Calendar Year;
  - (ii) bitewing x-rays, but not more often than twice in a Calendar Year;
  - (iii) topical application of fluoride for Dependent children under age 19, but not more than twice in a Calendar Year;
  - (iv) sealants for Dependent children under age 19;
  - (v) emergency palliative treatment; and
  - (vi) full mouth or panoramic x-rays, but not more than once in any 36-consecutive-month period.
- (e) Basic and Restorative Services include:
  - (i) extractions;
  - (ii) oral surgery;
  - (iii) amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations;
  - (iv) crowns if there is insufficient tooth structure to retain an amalgam, silicate, or plastic restoration;
  - (v) general anesthetics when Medically Necessary and administered in connection with oral or dental surgery;
  - (vi) treatment of periodontal and other diseases of the gums and tissues of the mouth;

- (vii) endodontic treatment, including root canal therapy;
  - (viii) repair or recementing of crowns, inlays, onlays, bridgework or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of 36 consecutive months;
  - (ix) initial installation of fixed bridgework to replace missing natural teeth (including inlays and crowns and abutments);
  - (x) initial installation of partial or full dentures (including precision attachments and any adjustments during the six-month period following installation);
  - (xi) replacement of an existing bridge, crown or denture, but only if:
    - (A) the replacement was installed at least five years prior to its replacement;
    - (B) the replacement is required to replace one or more natural teeth extracted after the existing bridge, crown or denture was installed; or
    - (C) the existing bridge, crown or denture was damaged as the result of an Injury received and cannot be made serviceable; and
  - (xii) implants.
- (f) (i) Covered orthodontic services (Dependent children under age 19 only) include:
- (A) the appliance, placement of the appliance, continuing treatment;
  - (B) any preliminary studies performed;
  - (C) cephalometric radiographs;
  - (D) diagnostic casts; and
  - (E) retainers and retainer devices.
- (ii) *Orthodontic Treatment Plan*

When an orthodontist recommends appliance therapy for a Dependent child under age 19, the orthodontist must submit a

treatment plan to the Administrative Manager. The following information should be provided:

- (A) total fee;
- (B) cost for initial placement of appliance;
- (C) estimated number of months of treatment; and
- (D) monthly treatment fee.

**Section 6. Exclusions and Limitations.**

No benefits shall be payable under this Article for the following:

*Section 6(a)  
amended effective  
January 1, 2008  
(see Amendment  
No. 8).*

- (a) any procedure, other than orthodontics, which was incurred or began before the date the covered person's dental coverage starts;
- (b) prescribed drugs and medicines, analgesia or local anesthesia;
- (c) replacement of a lost or stolen appliance;
- (d) any expense covered under the Comprehensive Medical Expense Benefit;
- (e) instructions for plaque control, oral hygiene and diet;
- (f) cosmetic dentistry;
- (g) temporary bridges, dentures or crowns;
- (h) charges for procedures, which are Experimental or Investigational in nature, or are not generally recognized by the dental profession for the condition being treated;
- (i) infection control costs;
- (j) procedures, appliances or restorations, other than fillings, that are necessary to alter, restore or maintain occlusion, except those listed in Section 5 of this Article as a Covered Dental Expense;
- (k) charges for completion of claim forms or charges for missed or broken appointments;
- (l) subgingival curettage and/or root planing (ADA codes 4220, 4331, and 4345) unless the presence of periodontal disease is confirmed by x-ray and periodontal charting of pocket depths for each tooth involved; or

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- (m) charges for any procedure not completed, or any prosthetic appliance unless the appliance is actually inserted or delivered.
- (n) expenses specified as not payable in Article 18, General Plan Exclusions and Limitations.

## **ARTICLE 15 – FAMILY SUPPLEMENTAL BENEFIT**

### **Section 1. General.**

Participants in Benefit Plans that include Family Supplemental Benefits may be able to receive reimbursement for certain specified Eligible Expenses that are Medically Necessary non-covered expenses.

### **Section 2. Benefits Payable.**

Eligible Expenses are payable under this Article up to the maximum per family per Calendar Year specified on the Participant's Schedule of Benefits.

### **Section 3. Reimbursement Procedures.**

Claims for Eligible Expenses under this Article must be:

- (a) submitted with a completed Family Supplemental Benefit claim form;
- (b) include itemized bills;
- (c) include paid receipts; and
- (d) submitted within one year (twelve months) after the expense is incurred.

### **Section 4. Eligible Expenses.**

- (a) Eligible Expenses under this benefit are Medically Necessary non-covered unreimbursed medical, dental or pharmacy expenses incurred by an Eligible Employee or Eligible Dependent, provided that the expense would be deductible under Section 213(d) of the Internal Revenue Code, including:
  - (i) Plan allowable amounts over a Plan maximum, and
  - (ii) Plan benefits payable at 50% other than as a penalty for not following the Plan rules and regulations.
- (b) Eligible Expenses include, but are not limited to the following:
  - (i) eye exams and prescription eyeglasses or contact lenses;

- (ii) hearing tests and hearing aids;
  - (iii) orthodontic expenses in excess of the Participant's lifetime orthodontia maximum;
  - (iv) routine physicals for children over the age of 2;
  - (v) dental expenses in excess of the Participant's Dental Benefits maximum benefit;
  - (vi) contraceptive devices such as diaphragms that are not covered under any other Plan benefit; and
  - (vii) genetic testing.
- (c) Requests for reimbursement must be received by the Fund Office within one year (twelve months) after the expense was incurred.

**Section 5. Exclusions and Limitations.**

No benefits shall be payable under this Article for:

- (a) expenses which are not Medically Necessary;
- (b) deductibles;
- (c) Co-Pay amounts;
- (d) expenses which are not deductible under Section 213(d) of the Internal Revenue Code;
- (e) medicines and drugs that do not require a prescription to purchase;
- (f) weight loss programs;
- (g) smoking cessation programs;
- (h) exercise programs, health club dues or membership fees;
- (i) hot tubs or jacuzzis;
- (j) cosmetic treatments such as teeth bleaching kits or treatments, cosmetic surgery, facials, etc.;
- (k) charges that are in excess of Reasonable and Customary Charges;
- (l) dental charges in excess of the Allowable Charge;

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- (m) pharmacy Co-Pays;
- (n) group insurance premiums for your spouse's employer's health plan; or
- (o) school expenses, including costs related to special educational programs for problem children.

## ARTICLE 16 – SUBROGATION

### Section 1.

Whenever a Participant shall, as a result of the tortious act or conduct of any person or persons, party or parties, firm or corporation, have a claim or demand against such other person or persons, party or parties, insurance company, firm or corporation arising from and in connection with the loss suffered by such Participant's benefits provided hereunder described in this Health and Welfare Plan, will be paid by the Trustees, as thereunder provided. The Trustees, however, to the extent of benefits paid, or to be paid, under the provisions of this Health and Welfare Plan, in consideration of the payment of benefits made hereunder, shall be subrogated to any and all rights of such Participant against such other person or persons, party or parties, insurance company, firm or corporation, including, but not limited to, the tortfeasor.

The Trustees shall have a lien to the extent of the benefits payable, which lien may be filed with any person or persons, party or parties, insurance company, firm or corporation claimed to be liable to the Participant on account of the loss incurred and the damages suffered. Plan benefits are not payable unless the Trustees have received a completed and fully executed subrogation document.

It shall be the duty of each Participant to notify the Trustees of any claim or demand he or she may have against any person or persons, party or parties, insurance company, firm or corporation, and of action or actions taken, or to be taken, in connection therewith.

Upon any recovery made by a Participant from any person or persons, party or parties, insurance company, firm or corporation, whether by suit, judgment, settlement, compromise, or otherwise, the Trustees, with or without the filing of a lien as above permitted, shall be entitled to immediate reimbursement to the extent of benefits paid in accordance with this Section 1 of Article 16. The Trustees shall be first reimbursed fully by such Participant or his attorney or agent, to the extent of benefits paid in accordance with this Section 1 of Article 16 from the monies paid by any person or persons, party or parties, insurance company, firm or corporation, and the balance of monies, if any, then remaining from such recovery shall be retained by the Participant. The rights of the Trustees to immediate reimbursement, as herein provided, shall be subject to a deduction, on a pro rata basis, for any reasonable legal fees and expenses, if any, authorized by the Trustees and necessarily incurred in affecting recovery of any benefits paid or to be paid.

*Section 1, Paragraph 5 amended effective October 27, 2009 (see Amendment No. 18).*

Upon receipt of a copy of the binding Settlement Agreement, properly executed by all relevant parties, and the appropriate recovery, the Trustees, at their discretion, will not consider for reimbursement any expense incurred for the care or treatment of the condition, which arose as a result of the accident or Illness, for a period not to exceed two years from the date the settlement was executed.

Anything in this Section 1 of this Article 16 contained to the contrary notwithstanding, the provisions hereof shall in no manner have application to a claim or demand of an Employee compensable under provisions of the Worker's Compensation Laws or similar legislation.

## **Section 2.**

Whenever a Participant shall, as a result of a Work-Related Illness or Injury incurred while an Employee of any party or parties, firm or corporation, have a claim or demand against such other person or persons, party or parties, insurance company, firm or corporation arising from and in connection with the loss suffered by such Participant's benefits provided hereunder described in this Health and Welfare Plan, will be paid by the Trustees, as thereunder provided. The Trustees, however, to the extent of benefits paid, or to be paid, under the provisions of this Health and Welfare Plan, in consideration of the payment of benefits made hereunder, shall be subrogated to any and all rights of such Participant against such other person or persons, party or parties, insurance company, firm or corporation, including, but not limited to, the tortfeasor.

The Trustees shall have a lien to the extent of the benefits payable, which lien may be filed with any person or persons, party or parties, insurance company, firm or corporation claimed to be liable to the Participant on account of the loss incurred and the damages suffered. Plan benefits are not payable unless the Trustees have received a completed and fully executed subrogation document.

It shall be the duty of each Participant to notify the Trustees of any claim or demand he or she may have against any person or persons, party or parties, insurance company, firm or corporation, and of action or actions taken, or to be taken, in connection therewith.

Upon any recovery made by a Participant from any person or persons, party or parties, insurance company, firm or corporation, whether by suit, judgment, settlement, compromise, or otherwise, the Trustees, with or without the filing of a lien as above permitted, shall be entitled to immediate reimbursement to the extent of benefits paid in accordance with this Section 2 of Article 16. The Trustees shall be first reimbursed fully by such Participant or his attorney or agent, to the extent of benefits paid in accordance with this Section 2 of Article 16 from the monies paid by any person or persons, party or parties, insurance company, firm

or corporation, and the balance of monies, if any, then remaining from such recovery shall be retained by the Participant. The rights of the Trustees to immediate reimbursement, as herein provided, shall be subject to a deduction, on a pro rata basis, for any reasonable legal fees and expenses, if any, authorized by the Trustees and necessarily incurred in affecting recovery of any benefits paid or to be paid.

*Section 2, Paragraph 5 amended effective October 27, 2009 (see Amendment No. 18.).*

Upon receipt of a copy of the binding Settlement Agreement, properly executed by all relevant parties, and the appropriate recovery, the Trustees, at their discretion, will not consider for reimbursement any expense incurred for the care or treatment of the condition, which arose as a result of the accident or illness, for a period not to exceed two years from the date the settlement was executed.

## ARTICLE 17 – RETIREE BENEFITS

The benefits provided for individuals who meet the eligibility requirements in this Article 17 are set forth in the Appendix on the Schedule of Benefits for Plan A-6.

### **Section 1. Eligibility.**

- (a) Subject to the requirements of Subsection 1(b) below, Retiree Benefits are provided for the following retired persons:
  - (i) Plan A Bargaining Unit Employees;
  - (ii) Plan A City of Chicago Employees;
  - (iii) Plan A Staff Employees;
  - (iv) Plan A Owner/Relatives; and
  - (vi) Plan A Municipality Employees.
- (b) A retiree in one of the categories listed in Section 1(a) above will be eligible for Retiree Benefits if he meets all of the following requirements:
  - (i) he has reached retirement age and retired from active employment;
  - (ii) he is receiving a Normal Retirement Pension, Early Retirement Pension, or Total and Permanent Disability Pension under the Midwest Operating Engineers Pension Plan, or with respect to a Municipality Employee, under the Illinois Municipality Retirement Fund;
  - (iii) he has accumulated ten years of Credited Service under the Midwest Operating Engineers Pension Plan, or with respect to a Municipality Employee, ten years under the Illinois Municipality Retirement Fund;
  - (iv) he has been covered as an active Employee under this Plan for at least ten years, except as follows for Municipality Employees:
    - (A) if an employee is a member of the bargaining unit represented by the Union on the effective date of the initial collec-

tive bargaining agreement between the Union and the Municipality; and

- (B) the Municipality on the effective date of the initial collective bargaining agreement provided retiree health benefits which were paid in whole or in part by that Employer; then
  - (C) the Employee who meets the requirements of subparagraphs (A) and (B) above will be deemed to have been covered by this Plan as an active Employee for ten (10) years, even if he has been covered under this Plan for less than 10 years; and
- (v) he has not, as of the date of his retirement, lost eligibility under this Plan for a period in excess of twelve (12) consecutive Months, or as an Employee of the Union or the Midwest Operating Engineers Welfare Fund, or the Midwest Operating Engineers Pension Trust Fund, or the Midwest Operating Engineers Construction Industry Research Service Trust Fund, or the Operating Engineers Local 150 Apprenticeship Fund, or the Local 150, I.U.O.E. Vacation Savings Plan, or the Midwest Operating Engineers Information Technology Services Corporation, accumulated less than 20 years of credited service under the Midwest Operating Engineers Pension Plan. If an Employee is awaiting the outcome of a Worker's Compensation Disability decision, such 12-Month period shall be extended to 36 Months. If the Employee was eligible under this Plan at the time of a Total Disability and such Disability is continuous to the date of his retirement, as determined by the Trustees, this requirement does not apply.
- (c) However, an Employee who has lost eligibility under this Plan for a period in excess of twelve (12) consecutive Months may regain eligibility if, prior to his retirement, he again becomes eligible under this Plan and remains eligible for the lesser of;
- (i) a consecutive period equal to the length of time he was not eligible for benefits under this Plan; or
  - (ii) 36 consecutive Months.
- (d) Railroad Employees
- (i) An employee who is working under the Landscape Contractors Labor Agreement may be eligible as a Retiree under this Plan, provided he meets all of the following requirements:

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- (A) he has reached retirement age and retired from active employment;
  - (B) he was covered as an active Employee for at least twelve (12) consecutive Months under this Plan prior to January 1, 1998;
  - (C) he was eligible under the Railroad Maintenance and Industrial Health and Welfare Fund during the 12 consecutive Months immediately prior to retirement;
  - (D) he has been covered as an active employee under this Plan or the Railroad Maintenance and Industrial Health and Welfare Fund for at least ten (10) years;
  - (E) he has accumulated at least ten (10) years of credited service under the Midwest Operating Engineers Pension Plan; and
  - (F) he is receiving a Normal Retirement Pension, Early Retirement Pension, or Total and Permanent Disability Pension under the Midwest Operating Engineers Pension Plan.
- (ii) Any period of coverage under the Railroad Maintenance and Industrial Health and Welfare Fund shall not be counted as a period of coverage under this Plan for the purpose of determining the amount the Retiree is required to self-pay for Retiree Benefits under this Plan.
- (e) A Retiree who meets the above stated requirements shall become covered for Retiree Benefits by making the proper application and self-payment to the Fund during the first Month after retirement. A Retiree may elect to cover only himself, or may elect to cover himself and his Eligible Dependents.
- (f) A Retiree who initially elects to cover only himself, may make a subsequent election to cover any newly acquired Eligible Dependent by making the proper application and self-payment to the Fund. Coverage for those Eligible Dependents shall become effective on the first day of the Month after the application is received. A Retiree shall have a six-month period from the date he first acquires a new Dependent to apply for coverage of such Dependent in order to be considered an Eligible Dependent under the Plan. Coverage for the Eligible Dependents of a Retiree shall become effective on the first day of the Month after the application is received.
- (g) Retirees must self-pay for Retiree Benefits for themselves and their Eligible Dependents. Payments are due to the Fund by the 15th day of the

prior Month, however, the Plan provides a 30-day grace period. The Fund may refuse to accept payments received after the expiration of the grace period.

- (i) The first and all subsequent self-payments shall be the retiree self-payment amount. The Trustees, in their sole discretion, will determine the self-payment amount and will notify the Retiree.
  - (ii) If a Participant has a bank of hours, he may continue running out those hours as an Active Participant. The self-payment amount for the last period during which he still has hours shall be the lesser of the active self-payment rate or the retiree self-payment rate. All subsequent self-payments shall be the retiree self-payment amount.
- (h) Eligibility for Retiree Benefits will terminate on the earliest of the following:
- (i) the date the required self-payment is not received by the Fund;
  - (ii) the date of termination of this Plan; or
  - (iii) the death of the Retiree.
- (i) Upon becoming eligible as a Retiree, the Fund will allow the Retiree to return to work as an active Employee one time without affecting his eligibility for Retiree Benefits. A “return to work” is defined as: (1) For a Retiree between the ages of 55 and 59, working one or more hours; or (2) For a Retiree between the ages of 60 and 70.5, working over 40 hours in any month. (This provision does not apply to a return to work by a Retiree age 70.5 or older.) If the Retiree returns to work a second time, under either or both definitions, he will no longer be eligible for Retiree Benefits. There is one exception to this rule: Eligibility for Retiree Benefits will not terminate if the Trustees determine that there is a need for the employment of retirees where there are no active employees available to perform such work.
- (j) Self-payments will be required for a Retiree who returns to active employment. Failure to make these payments will result in termination of eligibility.
- (k) The Plan provides special enrollment rights to eligible Dependents of Retirees who initially decline Retiree Benefits in writing and within the specified timeframe because the Dependent was covered under another group health plan or had health insurance coverage at that time. The Dependent must subsequently lose such other coverage for reasons

other than fraud or failure to make the required payments. The Retiree must make application for coverage for such Dependent within 30 days after the date the other coverage ends. The first self-payment for coverage must be made within 30 days of the date the application is made.

**Section 2. Benefits.**

Retirees are eligible for all benefits provided under their applicable Schedule of Benefits as set forth in the Appendix.

**Section 3. Eligibility for Survivor Benefits.**

- (a) Surviving Dependent spouses of deceased Retirees whose eligibility is due to terminate due to the Retiree's death may elect to continue coverage by making self-payments at the monthly rate specified by the Board of Trustees. The surviving spouse may continue coverage for herself and all Dependent children who were covered under the Plan on the day before the Retiree's death.
- (b) Surviving spouses of Retirees who make the required self-payments shall remain eligible for Retiree Benefits as set forth in Section 2 of this Article 17.
- (c) A surviving Dependent spouse's or child's eligibility will end on the earliest of the following:
  - (i) the date the required self-payment is not made;
  - (ii) the date of termination of this Plan;
  - (iii) the date the spouse remarries;
  - (iv) the date a child no longer meets the definition of Dependent;
  - (v) the death of the surviving spouse;
  - (vi) when the spouse or Dependent child becomes entitled to coverage under another group policy or plan, including Medicare; or
  - (vii) when the spouse establishes permanent residence outside the continental limits of the United States.
- (d) COBRA Coverage, as described in Section 2(q) of Article 3, is also available to qualified Dependent spouses and Dependent children. It can be elected in lieu of the coverage described above or, if the Dependent chooses Survivor Benefits and it ends before the expiration of 36-months

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from the death of the Retiree, the Dependent may elect COBRA for the balance of the 36-month period.

## ARTICLE 18 – GENERAL PLAN EXCLUSIONS AND LIMITATIONS

### Section 1. Conditions Governing Payment of Benefits.

Notwithstanding any other provision of the Plan to the contrary, and unless specifically stated otherwise, Covered Expenses shall not include, and no payment shall be made under the Plan, for charges for any of the following:

- (a) services or supplies which are not Medically Necessary;
- (b) any bodily Injury or Illness for which the Participant for whom claim is made is not under the care of a Physician;
- (c) any Injury, Illness or dental treatment for which an Eligible Employee has received or is entitled to receive benefits under a Workers' Compensation or Occupational Disease law or similar legislation, or which arise out of or in the course of any occupation or employment, except that:
  - (i) if death results and if the Employee is eligible for Death Benefits, Death Benefits shall nevertheless be paid;
  - (ii) if dismemberment results and if the Employee is eligible for Accidental Dismemberment Benefits, Accidental Dismemberment Benefits shall nevertheless, be paid; or
  - (iii) except as provided under Article 16, in the event that liability for the Illness or Injury is disputed by the insurance carrier providing Workers' Compensation coverage to the Employer, the Trustees, in their sole discretion, may reimburse the injured eligible person to the full extent of benefits provided under this Plan, or, in the alternative, reimburse the eligible person a portion of the expenses compensable under this Plan, provided, however, that the eligible person shall be required to execute a Subrogation Agreement prior to any reimbursement;
- (d) any supplies or services:
  - (i) for which no charge is made; or
  - (ii) for which the individual is not legally required to pay;

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- (e) any expense for which the Participant has or had a right to payment under:
  - (i) Medicare; or
  - (ii) CHAMPUS/TRICARE;
- (f) supplies and services which the Participant received from the uniformed services medical care facilities;
- (g) deductibles or Co-Pay amounts;
- (h) Experimental or Investigational services;
- (i) services provided by a parent, spouse, child, brother or sister of the Eligible Employee or his Eligible Dependent;
- (j) any expense incurred while coverage is not in force;
- (k) smoking cessation programs;
- (l) any service or supply not listed as a Covered Expense.
- (m) food supplements;
- (n) amounts in excess of Reasonable and Customary Charges;
- (o) any expense for failure to keep a scheduled visit;
- (p) completion of a claim form or supplemental report;
- (q) treatment of a condition or related condition that is a result of the commission of a felony, or a condition or related condition that is a result of war or any act of war, whether war is declared or undeclared;
- (r) medical services or supplies rendered or provided outside the United States, unless:
  - (i) while on work assignment, vacation or as a full-time student participating in a school sponsored program at a location outside the United States; and
  - (ii) treatment is given for an accident or an unforeseen and acute medical emergency.
- (s) infertility;
- (t) complications from non-covered procedures;

*Section 1(q)*  
*amended effective*  
*January 1, 2008*  
*(see Amendment*  
*No. 8).*

- (u) the cost of an electronic or microprocessor-controlled artificial limb in excess of the cost of a conventional mechanical prosthetic that would meet the patient's basic needs;
- (v) services rendered by athletic trainers, kinesiologists, massage therapists, recreational therapists, therapy aides/assistants or any other non-therapist professionals, even if a covered provider is supervising the therapy or billing for the treatment; or
- (w) medical, surgical, psychiatric or prescription drug treatment related to transsexual (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.
- (y) contraceptives, except as specifically provided.

**Section 2. Other Conditions Governing Benefits**

- (a) The list specified in Section 1 above does not provide an all-inclusive listing of the Plan's limitations and exclusions with respect to charges incurred for various procedures, services and supplies or with respect to circumstances that may cause other loss. It is only representative of the types of charges for which Plan benefits are limited or not payable, of the types of situations in which charges are incurred for which Plan benefits are limited or not payable, and of the types of circumstances that may cause other loss.
- (b) Additional coverage limitations are set forth in the other Articles of this Plan.

## ARTICLE 19 – COORDINATION OF BENEFITS

### Section 1. General.

The benefits payable to a Participant under this Plan, other than Weekly Disability Benefits, Prescription Drug Program benefits, Family Supplemental Benefits, and Life and AD&D Benefits shall be reduced to the extent necessary so that the sum of the benefits payable under this Plan and the benefits payable by any “Other Plan” shall not exceed the total that would be covered by either this Plan or the Other Plan.

### Section 2. Other Plan.

“Other Plan” shall mean any plan providing benefits or services for or by reason of medical or dental treatment for which benefits or services are provided by:

- (a) group, blanket or franchise insurance coverage (including student accident coverage);
- (b) prepayment coverage on a group basis, including Health Maintenance Organizations (HMOs) whether or not HMO requirements are followed;
- (c) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits for individuals of a group;
- (d) any coverage under governmental programs, and any coverage required or provided by any statute;
- (e) any no-fault automobile insurance coverage;
- (f) other arrangements of covered or self-covered group coverage;
- (g) plans for which any employer directly or indirectly, has made contributions or payroll deductions; or
- (h) dependent benefits payable under this Plan when a spouse is covered both as an Employee and as a Dependent and when a child is covered as a Dependent of more than one Employee.

**Section 3. Allowable Expense.**

- (a) “Allowable Expense” means any necessary, Reasonable and Customary Charge incurred by a Participant during a Calendar Year and while eligible under this Plan, for medical care or treatment, part or all of which would be covered under any of the Plans. Allowable Expenses do not include weekly disability benefits, prescription drug program benefits, family supplemental benefits, or life and AD&D benefits.
- (b) When benefits are reduced by a primary Plan because a Participant did not comply with the plan’s provisions, such as the provisions related to Case Management in this Plan and similar provisions in other plans, or use of certain providers under a PPO or HMO plan, the amount of those reductions will not be considered an Allowable Expense by this Plan when it pays secondary. Allowable Expense includes both assigned and non-assigned expenses.
- (c) When any Other Plan provides services rather than cash payment, the reasonable cash value of each service will be an Allowable Expense.
- (d) If either Plan has a contract with the provider, including a PPO or HMO agreement, the combined payments of both Plans will not be more than the contracted or negotiated fee.
- (e) If both this Plan and the Other Plan have a contract with the same provider, the allowable expense will be the lesser of the two contracted or negotiated fees.

**Section 4. Order of Benefit Payment.**

The first to apply of the following rules shall be used to determine the amount of benefits payable under this Plan and the amounts to be paid by any other plans:

- (a) A plan without coordination of benefits shall pay its benefits before a plan, which contains coordination of benefits.
- (b) A plan, which covers a person as an active eligible employee, shall pay its benefits before a plan, which covers the person as a laid-off or retired employee.
- (c) A plan, which covers a person other than as a dependent, shall pay its benefits before a plan, which covers the person as a dependent.

- (d) For claims on behalf of children who are covered under both parents' plans and the parents are not divorced or separated, whether or not they were ever married:
  - (i) the plan that covers the parent whose birthday falls earlier in the calendar year shall pay first,
  - (ii) if both parents have the same birthday, the plan covering the parent for the longer period of time shall pay first,
  - (iii) if one plan uses the male/female rule and the other plan coordinates using the rule based on the parents' birthdays, the plan using the male/female rule shall pay its benefits first.
  
- (e) For claims on behalf of children who are covered under both parents' plans and the parents are divorced or separated, whether or not they were ever married:
  - (i) If there is a court decree which establishes financial responsibility for the child's medical and other health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such legal financial responsibility shall pay its benefits first;
  - (ii) In the absence of a court decree establishing legal financial responsibility for the child's medical and other health care expenses, the plan which covers the child as a dependent of the parent with custody of the child shall pay first;
  - (iii) In the absence of a court decree establishing legal financial responsibility for the child's medical and other health care expenses, and if the parent with custody of the child has remarried:
    - (A) The plan which covers the child as a dependent of the parent with custody shall pay its benefits before a plan which covers the child as a Dependent of the stepparent, and
    - (B) The benefits of a plan which covers the child as a dependent of a stepparent shall pay before the benefits of a plan, which covers the child as a Dependent of the parent without custody.
  
- (f) If none of the above establishes the primary plan, the plan which has covered the person for the longer continuous period of time shall pay its benefit before the plan which has covered the person for a shorter period of time.

**Section 5. Benefit Credit Account.**

Any benefit savings resulting from coordination of medical benefits in a Calendar Year will be held in the Eligible Employee's or Eligible Dependent's benefit credit account for payment of Covered Expenses on the person's future medical claims incurred in that Calendar Year.

**Section 6. Effect of Medicare.**

This Plan shall coordinate benefits with Medicare when legally possible. For purposes of determining the Allowable Expense, the provisions of Article 20 shall apply.

**Section 7. Coordination with a Wraparound Plan or Subplan.**

Notwithstanding any provision contained in the Plan to the contrary, if the Other Plan contains a provision whereby the benefits payable under the Other Plan are reduced because of, or by reason of, benefits payable under this Plan (sometimes called a "wraparound plan" or "subplan"), any and all benefits payable under this Plan for such a claim shall be payable as if the Other Plan's benefits had not been reduced and had been paid without regard to such reduction.

## **ARTICLE 20 – EFFECT OF MEDICARE**

### **Section 1. General.**

The benefits payable to a Participant shall be reduced to the extent necessary so that the sum of the benefits payable under this Plan and the amounts paid under Medicare Part A and Part B shall not exceed the total of such “Allowable Expenses.”

### **Section 2. Allowable Expenses.**

“Allowable Expenses” means the lesser of the charges for medical care or treatment which are covered by this Plan or Medicare.

### **Section 3. Effect on Benefits and Coverage.**

If a Participant is eligible for Medicare or could be eligible for Medicare, the benefits provided to him under this Plan shall be reduced by the amount payable under Medicare or could have been payable under Medicare to the extent necessary so that the sum of the benefits under this Plan and Medicare shall not exceed the total Allowable Expenses, in accordance with the following provisions:

- (a) If a Participant is eligible for hospital insurance under Medicare Part A, the benefits provided to him under this Plan shall be reduced so that the sum of this Plan’s benefits and Medicare Part A benefits shall not exceed the Allowable Expenses for the hospital charges.
- (b) If a Participant is eligible to enroll in Medicare Part B, the benefits provided to him under this Plan shall be paid as if the Participant has enrolled in Part B, whether or not the Participant is actually enrolled in Part B.
- (c) If a Participant uses a provider that is covered under a Medicare Part C plan, no benefits shall be payable by this Plan.
- (d) If a Participant is covered under a Medicare Part D plan, no prescription drug benefits shall be payable by this Plan.
- (e) If a Participant is enrolled in a Medicare supplemental insurance (Medigap) plan or in a managed care plan (such as an HMO), this Plan shall coordinate its benefits so that the sum of this Plan’s benefits and

the other Plan's benefits, or the reasonable cash value of the managed care plan's benefits, shall not exceed the Allowable Expenses for the services.

**Section 4. Order of Benefit Payment.**

- (a) This Plan shall have primary responsibility for expenses incurred by the Eligible active Employee or his Eligible Dependent who are eligible for Medicare and if the Eligible Employee is actively employed by an Employer which pays all or part of the required contributions for eligibility.
- (b) The Plan has secondary responsibility for the Eligible Employee and his Eligible Dependent if he is not actively employed by an Employer.
- (c) This Plan shall have primary responsibility for expenses incurred by an active Eligible Employee (as defined under Section 1862(b)(4)(B)(ii) of the Social Security Act, 42 USC 1395(b)(4)(B)(ii) and the regulations thereunder) and for the active Eligible Employee's Eligible Dependents who are eligible for Medicare benefits because he is disabled and has received Social Security disability benefits for 24 consecutive months.
- (d) The Plan shall have primary responsibility for the first 30 months for the claim of an active Eligible Employee or Eligible Dependent who is eligible for Medicare benefits because of end-stage renal disease where Medicare has secondary responsibility.

Medicare claims for reimbursement from the Plan shall be subject to the benefit claim procedures of the Plan, including time limits for filing and processing benefit claims.

**Section 5. Definitions.**

"Medicare Benefits" means benefits for services and supplies which the Eligible Employee or Eligible Dependent receives or is entitled to receive under Medicare Parts A and B.

## **ARTICLE 21 – RETIREE MEDICAL SAVINGS PLAN**

### **Section 1. General.**

- (a) The Retiree Medical Savings Plan (RMSP) was established June 1, 2007 for the purpose of helping retired Plan A Employees pay the cost of the retiree health care coverage provided by the Midwest Operating Engineers Health and Welfare Plan.
- (b) RMSP Individual Accounts are funded solely by RMSP Contributions and Investment Yields. Persons may not make self-payments or other transfers of money or credit into Individual Accounts.
- (c) Individual RMSP Accounts are maintained for each Participant for whom RMSP Contributions are received. When required by the terms of their collective bargaining agreement or participation agreement with the Trustees, participating Employers make RMSP Contributions to the Midwest Operating Engineers Welfare Fund which are credited to their Employees' Individual RMSP Accounts.
- (d) Notwithstanding subparagraph (c) above, if a participating Employer makes RMSP Contributions on behalf of an individual who is working in the jurisdiction of this Fund, but whose health and welfare contributions are being transferred to another welfare fund in accordance with a reciprocity agreement to which both funds are party, this Fund will retain those Contributions. This Fund will not transfer those Contributions to the other fund, nor credit them to an RMSP Account in the individual's name.

### **Section 2. Definitions Applicable to This Article.**

#### **(a) Application**

A form completed and signed by the Participant that provides the Participant's identification information, including but not limited to address, date of birth, and authorizes the Administrative Manager to use the Participant's Individual RMSP Account for Retiree Self-Pay or Supplemental Medical Benefits.

**(b) Beneficiary**

- (i) The individual(s) the Participant names on the RMSP Beneficiary Statement to receive RMSP benefits from his Individual Account following his death, limited to his Eligible Dependents as defined in Section 2(b)(ii) below. To be in force, the Participant's Beneficiary designation on the RMSP Beneficiary Statement must be on file at the Fund Office before his death. If more than one Beneficiary is named, but their respective interests are not stated, they will share equally. If the Participant has not named a Beneficiary, or if the last-named Beneficiary has died, RMSP benefits will be made, to the extent of his remaining Individual Account, to or for the Participant's surviving Eligible Dependents, equally if more than one, or if none, the balance in his Individual Account will be forfeited.
  
- (ii) For purposes of the RMSP, "Eligible Dependents" include the spouse of the Participant and his dependents (as defined in Section 752 of the Internal Revenue Code of 1986, as amended, without regard to Section 152(b)(1), (b)(2), and (d)(1)(B)). Specifically, such a dependent may be a "qualifying child" or a "qualifying relative" of the Participant. A qualifying child is a child or a descendant of such child or a brother, sister, stepbrother or stepsister of the Participant or a descendant of any such relative. A qualifying relative of the Participant is a child or descendant of a child, a brother, sister, stepbrother or stepsister, the father or mother, or an ancestor of either or a stepfather or stepmother; a son or daughter or sister of the Participant, a brother or sister of the father or mother of the Participant and a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the Participant; and an individual other than a spouse of the Participant who had the same place of abode of the Participant for the portion of the calendar year ending with the Participant's death. Also, for determining a qualifying relative, the Participant should have furnished over one-half (1/2) of the relative's support for the period of the calendar year ending with the Participant's death.

**(c) Effective Date of Participation**

The date an Employee first becomes a Participant in the RMSP.

**(d) Individual Account**

The record established and maintained for each Participant to record the RMSPP Contributions made on his behalf, including any adjustments made to the Participant's Individual Account.

**(e) Investment Yield**

The net gain or loss to the Fund from Retiree Medical Savings Plan investments.

**(f) Midwest Operating Engineers Health and Welfare Plan**

When used in this Article, this term means the plan of healthcare benefits other than the benefits provided under this Article that are provided by the Midwest Operating Engineers Welfare Fund, including the Family Supplemental Benefit.

**(g) Participant**

An Employee for whom Retiree Medical Savings Plan (RMSPP) Contributions have been made for at least 300 hours during any one Contribution Quarter during which he is also participating in the Midwest Operating Engineers Health and Welfare Plan. In such case, the Employee's Effective Date of Participation will be the first day of the corresponding Benefit Quarter. In the event of the Participant's death, his surviving Dependents will become Participants provided they are still eligible for coverage in the Midwest Operating Engineers Health and Welfare Plan.

**(h) RMSPP Contributions**

Contributions made to the Midwest Operating Engineers Welfare Fund by an Employer for the covered work performed by the employee that are designated as contributions to the employee's Retiree Medical Savings Plan Individual Account.

**(i) Tax-Qualified**

A healthcare expense or insurance policy that is considered a deductible medical expenses by the Internal Revenue Service (IRS).

**(j) Valuation Date**

January 1 of each Calendar Year.

**Section 3. Becoming a Participant.**

- (a) An Employee shall become a Participant in the Retiree Medical Savings Plan (RMSP) on the first day of a Corresponding Benefit Quarter after the Fund Office has received RMSP Contributions for 300 hours of work during a Contribution Quarter, in accordance with the following schedule:

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

- (b) If the Employee does not satisfy the Midwest Operating Engineers Health and Welfare Plan's initial eligibility requirements during a period of three consecutive rolling calendar years, all the RMSP Contributions made on his behalf will be forfeited for the first of the three consecutive rolling calendar years. Once an Individual RMSP Account has been forfeited, the forfeited amount will not be restored, even if the person re-enters covered employment and later becomes a Participant in the Plan.

**Section 4. Adjustments to Individual RMSP Accounts.**

As soon as practical after each annual Valuation Date the Trustees will determine the amount of each Participant's Individual Account in the following manner:

- (a) The amount in the Participant's Individual Account as of the last Valuation Date; plus
- (b) The RMSP Contributions made on the Participant's behalf since the last Valuation Date; plus
- (c) The pro-rata share of any RMSP Contributions made that are not allocated to an Individual Account due to the forfeiture rule set forth in subsection 3(b) above; plus
- (d) The Participant's share of the gross Investment Yield, determined as set forth in Section 5 below; minus

- (e) Any RMSP benefits paid on behalf of the Participant or his Eligible Dependents; minus
- (f) An administrative charge. The amount of the administrative charge is determined by the Trustees, and is applicable to Individual Accounts on a uniform basis, regardless of the amount in the account.

**Section 5. Allocation of Investment Yield.**

- (a) The Investment Yield to be credited to each Participant's Individual Account will be determined each Valuation Date by the Trustees based on the weighted average balance a Participant's Individual Account bears to the total assets attributable to the Retiree Medical Savings Plan.
- (b) Only persons who are Participants on the Valuation Date will be eligible to receive an Investment Yield.

**Section 6. Retiree Self-Pay Benefits.**

- (a) A Participant will be eligible for Retiree Self-Pay Benefits to the extent of the funds in his Individual RMSP Account if he retires and qualifies for Retiree Benefits from the Midwest Operating Engineers Health and Welfare Plan
- (b) Retiree Self-Pay Benefits are paid in the form of transfers from the Participant's Individual Account to the Midwest Operating Engineers Health and Welfare Plan in the amounts of the self-payments the Participant is required to make for Retiree Benefits.
- (c) The amount withdrawn from the Participant's Individual Account, and the dates of the withdrawals will be determined in accordance with the payment rates and payment due dates for the Midwest Operating Engineers Health and Welfare Plan's Retiree Benefits self-payments.
- (d) If and when the Participant's Individual Account has been exhausted, he can continue to make retiree self-pays to the Midwest Operating Engineers Health and Welfare Plan for Retiree Benefits. He will be entitled to additional Retiree Self-Pay Benefits from the RMSP if he returns to covered employment and once again accumulates funds in his Individual Account.
- (e) A Participant who is receiving Retiree Self-Pay Benefits may also use his Individual Account for the following Supplemental Medical Benefits for himself and his Eligible Dependents:

- (i) Premiums for a Tax-Qualified long-term care insurance policy; and
- (ii) Tax-Qualified expenses for nursing home, home health care and hospice care that are not payable by another insurance policy or plan, including the Midwest Operating Engineers Health and Welfare Plan.

**Section 7. Supplemental Medical Benefits.**

- (a) If a Participant retires on or after age 55 but is not eligible for Retiree Benefits from the Midwest Operating Engineers Health and Welfare Plan, or does not elect those benefits, his Individual RMSPP Account can be used for payment to or for himself and his Eligible Dependents for:
  - (i) Tax-Qualified expenses that are not paid under another group healthcare plan that covers the Participant, such as deductibles and co-pays, and charges in excess of that plan's benefit limits;
  - (ii) Tax-Qualified premiums to another group healthcare plan, Medicare Part B, a Medicare Advantage plan, a Medicare Part D (prescription drug) plan, or a Medicare supplement ("Medigap") plan;
  - (iii) Premiums for a Tax-Qualified long-term care insurance policy; and
  - (iv) Tax-Qualified expenses for nursing home, home health care and hospice care that are not payable by another insurance policy or plan, including the Midwest Operating Engineers Health and Welfare Plan.
- (b) This benefit may not be used to pay for life insurance policies, loss-of-earnings policies, accidental death and loss of limb, sight, etc. policies, daily indemnity policies that pay the policyholder a specified amount while hospitalized, med-pay coverage under vehicle insurance, or any taxes imposed by any governmental body.

**Section 8. Benefits Upon the Death of the Participant.**

- (a) If a Participant in the RMSPP dies, the amount in his Individual Account may be used to provide coverage for his Beneficiary(ies) who are eligible for coverage under the regular provisions of the Midwest Operating Engineers Health and Welfare Plan, including COBRA coverage. Any such coverage will be provided in accordance with the Health and Welfare Plan's surviving dependent or COBRA Coverage self-payment eligibility rules and coverage provisions.

- (b) A surviving Beneficiary who is eligible for Health and Welfare Plan coverage but who does not elect such coverage because of other group healthcare coverage, including Medicare, may elect to receive Supplemental Medical Benefits that are described in Section 7 above.

**Section 9. Application for Benefits.**

**(a) Filing an Application for Retiree Self-Pay Benefits**

- (i) In order for the Fund to use a Participant's Individual Account for Retiree Self-Pay Benefits, an Application must be filed with the Administrative Manager under the procedures described below. An application can be filed by the Participant, or in the event of the Participant's death, his surviving Beneficiary.
- (ii) The Application must be received by the Administrative Manager no later than the end of the calendar month immediately prior to the calendar month in which the Participant's Retiree Benefits become effective.
- (iii) An Application for Retiree Self-Pay benefits is considered to have been filed on the date the Application is received at the office of the Administrative Manager. Even if an Application is incomplete, it is considered to have been filed on the date the Administrative Manager first receives the Application.
- (iv) The applicant may designate another person as his authorized representative for purposes of filing an application. Such designations must be in writing, notarized or signed before a Plan representative, and received by the Plan.

**(b) Filing an Initial Application for Supplemental Medical Benefits**

- (i) In order for the Fund to use a Participant's Individual Account for Supplemental Medical Benefits, an initial Application and authorization must be filed with the Administrative Manager under the procedures described below. An application can be filed by the Participant, or in the event of the Participant's death, his surviving Beneficiary.
- (ii) The Application must be received by the Administrative Manager no later than end of the calendar month immediately prior to the calendar month in which the Participant retires.
- (iii) An application for Retiree Self-Pay benefits is considered to have been filed on the date the application is received at the office of

the Administrative Manager. Even if an Application is incomplete, it is considered to have been filed on the date the Administrative Manager first receives the application.

- (iv) The applicant may designate another person as his authorized representative for purposes of filing an application. Such designations must be in writing, notarized or signed before a Plan representative, and received by the Plan.

**Section 10. RMSP Claims.**

Claims for payment of Supplemental Medical Benefits from a Participant's Individual RMSP Account must be filed in accordance with the Midwest Operating Engineers Health and Welfare Plan's normal claim procedures and time limits.

**Section 11. RMSP Appeals.**

Each applicant or claimant whose Application or claim for benefits under this Article shall have been disapproved, in whole or in part, shall have the right to request a full and fair review of the determination so made, all in accordance with the Midwest Operating Engineers Health and Welfare Plan's normal procedures.

**Section 12. Restrictions on Individual Accounts.**

No Participant, Dependent or Beneficiary will have any vested interest or right, title, or other interest in the Trust or in an Individual Account. The assets of the RMSP are part of the total assets of the Midwest Operating Engineers Health and Welfare Fund and can be used to provide any of the health and welfare benefits provided by the Fund.

**SIGNATURE PAGE**

IN WITNESS WHEREOF, the Trustees of the Midwest Operating Engineers Welfare Fund have hereby adopted this Restated Plan Document by affixing their signatures as of this 15th day of July, 2008.

**Union Trustees**

**Employer Trustees**

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# **APPENDIX**

**Schedule of Benefits Plan A-1  
Quarterly Employees**

**Schedule of Benefits Plan A-2  
City of Chicago – Quarterly**

**Schedule of Benefits Plan A-3  
Non-bargaining Employees**

**Schedule of Benefits Plan A-4  
Staff, Owner/Operator**

**Schedule of Benefits Plan A-5  
Municipality – Monthly**

**Schedule of Benefits Plan A-6  
Retirees**

**Schedule of Benefits Plan B-1  
Plantmen**

**Schedule of Benefits Plan D-1  
Dental only**

**Schedule of Benefits Plan E-1  
Landscapers**

**All benefits are subject to eligibility, maximum plan benefit, reasonable and customary determination (or negotiated fee amounts for PPO provider services), pre-existing condition limitations and any special limits noted in the Plan. Charges that exceed the reasonable and customary amount or other Plan limitations will not be considered eligible in determining plan benefits. Eligible expenses must be medically necessary and are subject to the calendar deductible unless otherwise noted. Age limitations, as specified in the Schedule of Benefits, are applied as of the last day of the month in which the eligible dependent's birthday occurs.**

**SCHEDULE OF BENEFITS – Plan A-1**

**QUARTERLY EMPLOYEES**

**Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$3,000

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2009 (see Amendment No. 11).*

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc.	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including: organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2011 (see Amendment No. 17).*

*See Amendments No. 3 (effective January 1, 2009 and No. 12 (effective June 1, 2009) for additional limitations.*

## Prescription Drug Program

<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

Amended effective January 1, 2011 (see Amendment No. 17).

### Dental Benefits

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 only)	50%
	lifetime maximum \$1,500

See Amendment No. 3 (effective January 1, 2009).

### Disability Benefits

<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for up to 52 weeks. Eligibility is credited with 40 hours a week for the first 17 weeks
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### Death Benefit

<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
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### Accidental Dismemberment Benefit

<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
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### Family Supplemental Benefit

<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500
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**SCHEDULE OF BENEFITS – Plan A-2**

**City of Chicago - Quarterly  
Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only.</b> Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$3,000

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2009 (see Amendment No. 11).*

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc.	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2011 (see Amendment No. 17).*

*See Amendments No. 3 (effective January 1, 2009 and No. 12 (effective June 1, 2009) for additional limitations.*

## Prescription Drug Program

<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

*Amended effective January 1, 2011 (see Amendment No. 17).*

### Dental Benefits

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> )	50%
	lifetime maximum \$1,500

*See Amendment No. 3 (effective January 1, 2009).*

### Disability Benefits

<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for first 30 days
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### Death Benefit

<b>Death Benefit</b>	\$7,500 member \$2,000 dependent
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### Accidental Dismemberment Benefit

<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
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### Family Supplemental Benefit

<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500
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**SCHEDULE OF BENEFITS – Plan A-3**

**Non - Bargaining Employees**

**Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover does not apply.	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$3,000

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2009 (see Amendment No. 11).*

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits	<i>Amended effective January 1, 2011 (see Amendment No. 17).</i>
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network	
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350	
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000	<i>Amended effective January 1, 2011 (see Amendment No. 17).</i>
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network	<i>Amended effective January 1, 2011 (see Amendment No. 17).</i>
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000	
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500	
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%	<i>Amended effective January 1, 2011 (see Amendment No. 17).</i>
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000	<i>Amended effective January 1, 2011 (see Amendment No. 17).</i>
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500	
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only	
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000	<i>See Amendments No. 3 (effective January 1, 2009) and No. 12 (effective June 1, 2009) for additional limitations.</i>
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge	
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000	
<b>Mental Illness and Substance Abuse</b>		
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required		
Inpatient Care	90% lifetime maximum 30 days	<i>See Amendments No. 3 (effective January 1, 2009) and No. 12 (effective June 1, 2009) for additional limitations.</i>
Outpatient Care	90% lifetime maximum 60 visits	

<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 only)	50% lifetime maximum \$1,500
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

*Amended effective January 1, 2011 (see Amendment No. 17).*

*See Amendment No. 3 (effective January 1, 2009).*

**SCHEDULE OF BENEFITS – Plan A-4**

**Staff – Owner/Relatives**

**Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$3,000

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2009 (see Amendment No. 11).*

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits	Amended effective January 1, 2011 (see Amendment No. 17).
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network	
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350	
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000	
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network	Amended effective January 1, 2011 (see Amendment No. 17).
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000	Amended effective January 1, 2011 (see Amendment No. 17).
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500	
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%	
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90%- In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000	
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500	Amended effective January 1, 2011 (see Amendment No. 17).
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only	Amended effective January 1, 2011 (see Amendment No. 17).
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000	
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge	See Amendments No. 3 (effective January 1, 2009 and No. 12 (effective June 1, 2009) for additional limitations.
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000	
<b>Mental Illness and Substance Abuse</b>		
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required		
Inpatient Care	90% lifetime maximum 30 days	
Outpatient Care	90% lifetime maximum 60 visits	

## Prescription Drug Program

<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> )	50% lifetime maximum \$1,500
<b>Disability Benefits</b>	
<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for up to 52 weeks <b>Staff</b> – eligibility is credited with 40 hours per week for the first 17 weeks <b>Owner/Relative</b> – pays monthly, no credit is applied toward eligibility
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

Amended effective January 1, 2011 (see Amendment No. 17).

See Amendment No. 3 (effective January 1, 2009).

**SCHEDULE OF BENEFITS – Plan A-5**

Municipality - monthly

**Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$3,000

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2009 (see Amendment No. 11).*

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits	<i>Amended effective January 1, 2011 (see Amendment No. 17).</i>	
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network		
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350		
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000		
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network		<i>Amended effective January 1, 2011 (see Amendment No. 17).</i>
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000		
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500		
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%		<i>Amended effective January 1, 2011 (see Amendment No. 17).</i>
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000		
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500		<i>Amended effective January 1, 2011 (see Amendment No. 17).</i>
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only		
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000	<i>See Amendments No. 3 (effective January 1, 2009 and No. 12 (effective June 1, 2009) for additional limitations.</i>	
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge		
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000		
<b>Mental Illness and Substance Abuse</b>			
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required			
Inpatient Care	90% lifetime maximum 30 days	<i>See Amendments No. 3 (effective January 1, 2009 and No. 12 (effective June 1, 2009) for additional limitations.</i>	
Outpatient Care	90% lifetime maximum 60 visits		

## Prescription Drug Program

<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

Amended effective January 1, 2011 (see Amendment No. 17).

### Dental Benefits

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> )	50% lifetime maximum \$1,500

See Amendment No. 3 (effective January 1, 2009).

### Disability Benefits

<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for first 30 days
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### Death Benefit

<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
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### Accidental Dismemberment Benefit

<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
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### Family Supplemental Benefit

<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500
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**SCHEDULE OF BENEFITS – Plan A-6**

**Retirees**

**Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$3,000

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2009 (see Amendment No. 11).*



## Prescription Drug Program

<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

*Amended effective January 1, 2011 (see Amendment No. 17).*

### Dental Benefits

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 only)	50% lifetime maximum \$1,500

*See Amendment No. 3 (effective January 1, 2009).*

### Death Benefit

<b>Death Benefit</b>	\$10,000 – Local 537 members only
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### Family Supplemental Benefit

<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500
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**SCHEDULE OF BENEFITS – Plan B -1**

Plantsmen – monthly

**Comprehensive Medical Expense Benefits**

Benefits provided for in-network services only.

<b>Lifetime Maximum</b>	\$250,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$100
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$300
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	80%, if pre-approved by Case Manager
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	80%, if pre-approved by Case Manager Maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician.	80%, if pre-approved by Case Manager
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	80%
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	80%
<b>MRI and CT Scans</b>	90% - Medlink 80%, other in-network
<b>Outpatient Physical and Occupational Therapy</b> – Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	80%, if pre-approved by Case Manager
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> - must be performed by a Licensed Speech Therapist.	50%, if pre-approved by Case Manager
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5.	50%, if pre-approved by Case Manager calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18.	50%, if pre-approved by Case Manager calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only.</b>	50%, if pre-approved by Case Manager calendar year maximum \$3,000
<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only.</b> Training needs to be prescribed by a covered provider.	50%, if pre-approved by Case Manager lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc.	80%

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2009 (see Amendment No. 11).*

<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months.	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered.	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 80%, if pre-approved by Case Manager
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment.	No deductible 80%, if pre-approved by a case manager Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician.	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%, if pre-approved by Case Manager
<b>Transplants</b> - Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	80%, if pre-approved by Case Manager lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required.	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18.	80%, if pre-approved by Case Manager
<b>Cochlear Implants</b> – age 19 and older.	70%, if pre-approved by Case Manager lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	80% Inter-health-care-facility transfer maximum \$5,000

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2011 (see Amendment No. 17).*

*See Amendments No. 3 (effective January 1, 2009) and No. 12 (effective June 1, 2009) for additional limitations.*

*Amended effective January 1, 2011 (see Amendment No. 17).*

**Prescription Drug Program**

<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$7,500 per individual
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

**SCHEDULE OF BENEFITS – Plan D -1**

**Dental Only  
Dental Expense Benefits**

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> )	50% lifetime maximum \$1,500

*See Amendment No. 3 (effective January 1, 2009).*

**SCHEDULE OF BENEFITS – Plan E -1**

**Landscapers**

**Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b>	\$50,000
<b>Lifetime Maximum</b>	\$350,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$100
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$300
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 70% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 70% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 70% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 70% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 70% - Out of Network
<b>MRI and CT Scans</b>	90% - Medlink 90% - In Network 70% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 70% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 70% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 70% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 70% - Out of Network calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 70% - Out of Network calendar year maximum \$3,000
<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2009 (see Amendment No. 11).*

<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 70% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 70% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 70%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	70% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	70%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	70% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 70% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	\$50 combined calendar year deductible 90% lifetime maximum 30 days
Outpatient Care	\$50 combined calendar year deductible 90% lifetime maximum 60 visits

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2011 (see Amendment No. 17).*

*Amended effective January 1, 2011 (see Amendment No. 17).*

*See Amendments No. 3 (effective January 1, 2009 and No. 12 (effective June 1, 2009) for additional limitations.*

<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 day supply Generic \$5 co-pay – 30 day supply annual maximum \$10,000 per individual
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$600
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> )	50%
	lifetime maximum \$750
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$10,000 – member
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$500

*Amended effective January 1, 2011 (see Amendment No. 17).*

**AMENDMENT NO. 1  
TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Article 10 – Comprehensive Medical Expense Benefit

Section 8 – Covered Expenses

Effective Date and Explanation of Revision:

Effective for charges incurred on and after January 1, 2008, the scheduled benefit for physical and occupational therapy for congenital neurological disorders for dependent children under age 19 will also be provided for children age 19 or over who remain covered under the Plan's definition of an Eligible Dependent because they are incapable of self-sustaining employment by reason of mental retardation or physical handicap.

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this \_\_\_\_\_ day of \_\_\_\_\_.

\_\_\_\_\_  
JAMES M. SWEENEY

\_\_\_\_\_  
JOHN E. KENNY, JR.

\_\_\_\_\_  
STEVEN M. CISCO

\_\_\_\_\_  
ROB JOSEPH

\_\_\_\_\_  
MARSHALL DOUGLAS

\_\_\_\_\_  
MICHAEL D. PIRAINO

\_\_\_\_\_  
DAVID FAGAN

\_\_\_\_\_  
DAVID SNETTEN

\_\_\_\_\_  
JAMES J. McNALLY

\_\_\_\_\_  
GLEN WEEKS

## ARTICLE 10

### COMPREHENSIVE MEDICAL EXPENSE BENEFIT

#### Section 8. Covered Expenses.

- (y) **Physical and occupational therapy for congenital neurological diseases for dependent children through age 18 only,** up to the maximum benefit specified on the Participant's Schedule of Benefits. Congenital neurological diseases include cerebral palsy muscular dystrophy, Down's Syndrome and Edward's Syndrome. Services must be deemed Medically Necessary by the Case Manager. The age limit will not apply to a child age 19 or over who satisfies the Plan's definition of an Eligible Dependent because he is incapable of self-sustaining employment by reason of mental retardation or physical handicap.

**AMENDMENT NO. 2  
TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Article 10 – Comprehensive Medical Expense Benefit  
Section 8 – Covered Expenses

Effective Date and Explanation of Revision:

Effective for charges incurred on and after August 1, 2008, orthognathic (jaw) surgery will be covered if provided by a dentist (or physician) and deemed medically necessary by the Case Manager.

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this \_\_\_\_\_ day of \_\_\_\_\_.

\_\_\_\_\_  
JAMES M. SWEENEY

\_\_\_\_\_  
JOHN E. KENNY, JR.

\_\_\_\_\_  
STEVEN M. CISCO

\_\_\_\_\_  
ROB JOSEPH

\_\_\_\_\_  
MARSHALL DOUGLAS

\_\_\_\_\_  
MICHAEL D. PIRAINO

\_\_\_\_\_  
DAVID FAGAN

\_\_\_\_\_  
DAVID SNELTEN

\_\_\_\_\_  
JAMES J. McNALLY

\_\_\_\_\_  
GLEN WEEKS

**ARTICLE 10**

**COMPREHENSIVE MEDICAL EXPENSE BENEFIT**

**Section 8. Covered Expenses.**

- (ii) **Orthognathic (jaw) surgery** performed by a Physician or Dentist when deemed Medically Necessary by the Case Manager.

**AMENDMENT NO. 3**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Article 2 – Definitions

Article 10 – Comprehensive Medical Expense Benefit

Appendix – Schedules A-1, A-2, A-3, A-4, A-5, A-6, B-1, D-1 and E-1

Effective Date and Explanation of Revision:

- 1) Effective January 1, 2009, the Plan will cover acupuncture by a physician, or by a licensed acupuncturist when there is a physician referral. Coverage is limited to twelve visits per calendar year, and the allowable per visit is \$125.
- 2) Effective January 1, 2009, the Plan will cover colonoscopies performed for screening purposes when recommended by a physician.
- 3) Effective for courses of treatment that started on or after January 1, 2009, the Plan's lifetime maximum orthodontia benefit is increased to \$2,000 (from \$1,500). This increase does not apply to Plan E-1 (landscapers).

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this \_\_\_\_\_ day of \_\_\_\_\_.

\_\_\_\_\_  
JAMES M. SWEENEY

\_\_\_\_\_  
JOHN E. KENNY, JR.

\_\_\_\_\_  
STEVEN M. CISCO

\_\_\_\_\_  
ROB JOSEPH

\_\_\_\_\_  
MARSHALL DOUGLAS

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MICHAEL D. PIRAINO

\_\_\_\_\_  
DAVID FAGAN

\_\_\_\_\_  
DAVID SNETTEN

\_\_\_\_\_  
JAMES J. McNALLY

\_\_\_\_\_  
GLEN WEEKS

**ARTICLE 2**  
**DEFINITIONS**

**Section 25. Health Care Provider.**

- (y) Licensed acupuncturist.

**ARTICLE 10**  
**COMPREHENSIVE MEDICAL EXPENSE BENEFIT**

**Section 8. Covered Expenses.**

- (jj) **Cancer screening colonoscopies** recommended by a Physician.
- (kk) **Acupuncture** performed by a Physician, or licensed acupuncturist when referred by a Physician, subject to the limitations specified on the Participant's Schedule of Benefits.

**SCHEDULE OF BENEFITS – Plan A - 1**

**QUARTERLY EMPLOYEES  
Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$3,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Disability Benefits</b>	
<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for up to 52 weeks. Eligibility is credited with 40 hours a week for the first 17 weeks
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan A - 2**

**City of Chicago - Quarterly  
Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only.</b> Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$3,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Disability Benefits</b>	
<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for first 30 days
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$7,500 member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan A - 3**

**Non - Bargaining Employees  
Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$3,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan A - 4**

Staff – Owner/Relatives

**Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only.</b> Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$3,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90%- In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Disability Benefits</b>	
<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for up to 52 weeks <b>Staff</b> – eligibility is credited with 40 hours per week for the first 17 weeks <b>Owner/Relative</b> – pays monthly, no credit is applied toward eligibility
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan A - 5**

**Municipality - monthly  
Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only.</b> Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$3,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Disability Benefits</b>	
<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for first 30 days
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan A - 6**

**Retirees**

**Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only.</b> Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$3,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$10,000 – Local 537 members only
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan B - 1**

**Plantsmen – monthly  
Comprehensive Medical Expense Benefits**

<b>Lifetime Maximum</b>	\$250,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$100
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$300
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	80% - In Network only
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	80% - In Network only Maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	80% - In Network only
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	80% - In Network only
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	80% - In Network only
<b>MRI and CT Scans</b>	100% - Medlink 80% - In Network Only
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	80% - In Network only
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	50% - In Network only
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	50% - In Network only calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	50% - In Network only calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	50% - In Network only calendar year maximum \$3,000

<b>Orthoptic Training</b> – for dependent children up to age 10 only. Training needs to be prescribed by a covered provider.	50% - In Network only lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	80% - In Network only
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% - In Network only lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 80% - In Network only
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	70% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80% - In Network only
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	80% - In Network only lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	80% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% - In Network only lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	80% - In Network only Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 80% - In Network only

**Prescription Drug Program**

<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$7,500 per individual
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

**SCHEDULE OF BENEFITS – Plan D - 1**

**Dental Only  
Dental Expense Benefits**

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000

**SCHEDULE OF BENEFITS – Plan E - 1**

**Landscapers**

**Comprehensive Medical Expense Benefits**

<b>Lifetime Maximum</b>	\$350,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$100
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$300
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 70% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 70% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 70% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 70% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 70% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 70% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 70% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 70% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 70% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 70% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only.</b> Requires approval by Case Management.	90% - In Network 70% - Out of Network calendar year maximum \$3,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 70% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 70% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 70%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	70% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	70%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	70% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 70% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 70% - Out of Network

**Mental Illness and Substance Abuse**

<b>Mental Illness and Substance Abuse – prior authorizations from MAP provider is required</b>	
Inpatient Care	\$50 deductible 90% lifetime maximum 30 days
Outpatient Care	\$50 deductible 90% lifetime maximum 60 visits

**Prescription Drug Program**

<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 day supply Generic \$5 co-pay – 30 day supply annual maximum \$10,000 per individual
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

**Dental Benefits**

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> )	50% lifetime maximum \$750

**Death Benefit**

<b>Death Benefit</b>	\$1,000 – member
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**Family Supplemental Benefit**

<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$500
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**AMENDMENT NO. 4**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Article 4 – General Provisions

Effective Date and Explanation of Revision:

Effective January 1, 2009, the Plan will allow up to five years to file a claim for dismemberment benefits.

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this \_\_\_\_\_ day of \_\_\_\_\_.

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JAMES M. SWEENEY

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JOHN E. KENNY, JR.

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STEVEN M. CISCO

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ROB JOSEPH

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MARSHALL DOUGLAS

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MICHAEL D. PIRAINO

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DAVID FAGAN

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DAVID SNELTEN

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JAMES J. McNALLY

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GLEN WEEKS

## ARTICLE 4

### GENERAL PROVISIONS

#### Section 9. Claim Filing Procedures.

- (d) Claims must be filed within one year (twelve months) after the expense was incurred, except that claims for dismemberment benefits will be accepted for up to five years (sixty months) following the loss. It is the Participant's responsibility to see that claims and medical bills are submitted promptly and no later than the time period permitted under the Plan. However, written notice of death upon which a claim may be based must be given to the Fund Office within a reasonable period after the date of death. If the Fund Office requests additional information from the Participant or provider in order to process a claim, the requested information must be provided within the time period specified on the written request, or within one year from the date of service, whichever is later.

**AMENDMENT NO. 5**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Article 3 – Eligibility

Effective Date and Explanation of Revision:

Effective April 1, 2009, the entitlement of dependents of retirees, and non-bargaining unit employees and their dependents, to postpone Plan coverage because of other health plan coverage will also apply if the person is covered by Medicaid or a State Children’s Health Insurance Program (SCHIP). The late enrollment rights for dependents of retirees, and non-bargaining unit employees and their dependents, will apply in the event that the individual loses his or her Medicaid or SCHIP coverage.

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this \_\_\_\_\_ day of \_\_\_\_\_.

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JAMES M. SWEENEY

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JOHN E. KENNY, JR.

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STEVEN M. CISCO

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ROB JOSEPH

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DAVID FAGAN

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DAVID SNETTEN

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JAMES J. McNALLY

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GLEN WEEKS

**ARTICLE 3**

**ELIGIBILITY**

**Section 2. Eligibility for Benefit Plan A.**

**(b) Monthly Eligibility**

*(i) Non-Bargaining Unit Employees*

*(C) Declining Coverage*

The terms of the participation agreement allow Non-Bargaining Unit Employees to decline eligibility for himself and/or his Dependent(s), and to enroll in the Plan at a later date. Coverage may only be declined and late enrollment is only allowable if the Employee is covered under another group health plan (including Medicare, Medicaid or a State Children's Health Insurance Program (SCHIP)) or health insurance, subject to the following rules:

- (1) The Employee must complete and sign a waiver form, and provide proof of the other group health plan or health insurance coverage that is satisfactory to the Administrative Manager within 60 days of declining Plan eligibility.
- (2) If an Employee declines eligibility for himself or for his Dependent(s), including his spouse, because of other group health plan or health insurance coverage, the Employee may in the future enroll himself and his Dependents in the Plan, provided that the Employee requests enrollment within 60 days after the Employee's other coverage ends due to the exhaustion of the COBRA continuation maximum period of coverage, the termination of employer contributions for coverage in the other plan, or the loss of eligibility for Medicaid or SCHIP coverage, or the loss of eligibility in such other plan due to divorce, legal separation, death, termination of employment or reduction in hours. In addition, if the Employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the Employee may enroll himself and his Dependent(s), provided that the Employee requests enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

**ARTICLE 17**

**RETIREE BENEFITS**

**Section 1. Eligibility.**

- (k) The Plan provides special enrollment rights to eligible Dependents of Retirees who initially decline Retiree Benefits in writing and within the specified timeframe because the Dependent was covered under another group health plan (including Medicaid or a State Children's Health Insurance Program (SCHIP)) or had health insurance coverage at that time. The Dependent must subsequently lose such other coverage for reasons other than fraud or failure to make the required payments. The Retiree must make application for coverage for such Dependent within 30 days after the date the other coverage ends (60 days if the other coverage was Medicaid or SCHIP). The first self-payment for coverage must be made within 30 days of the date the application is made.

**AMENDMENT NO. 6**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Article 3 – Eligibility

Effective Date and Explanation of Revision:

Effective July 1, 2009, the self-payment rights of a Plan A quarterly bargaining unit employee will be postponed if the amount of his required quarterly self-payment is more than the government-subsidized COBRA premium rate. This provision will be in effect for the July 1, 2009 and October 1, 2009 benefit quarters only. Any postponed self-pay periods will resume when the employee's subsidized COBRA coverage period ends.

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this \_\_\_\_\_ day of \_\_\_\_\_.

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JAMES M. SWEENEY

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JOHN E. KENNY, JR.

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STEVEN M. CISCO

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ROB JOSEPH

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MARSHALL DOUGLAS

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MICHAEL D. PIRAINO

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DAVID FAGAN

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DAVID SNETTEN

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JAMES J. McNALLY

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GLEN WEEKS

**ARTICLE 3**

**ELIGIBILITY**

**Section 2. Eligibility for Benefit Plan A**

**(a) Quarterly Eligibility**

*(i) Bargaining Unit Employees*

*(F) Continuing Eligibility Through Self-Payment*

*(1) Self-Payments for Plan A Coverage*

*d. Postponement of Self-Pay Period*

1. If an Employee is eligible to make a self-payment for the July 1, 2009 and/or the October 1, 2009 Benefit Quarters, and is also eligible to pay a lesser amount for COBRA Coverage because of the COBRA subsidy provided through the American Recovery and Reinvestment Act of 2009 (ARRA), the Employee's quarterly self-payment period will be postponed until after his subsidized COBRA Coverage period ends. The amount the Employee will be required to self-pay for a previously postponed Benefit Quarter will be the amount he would have paid for the postponed quarter, or the amount otherwise due for the current Benefit Quarter, whichever is less.
2. The provisions set forth in No. 1 above will not apply to an Employee receiving Weekly Disability Benefits who wants to retain those benefits, or to an Employee who wants to retain his Death Benefit.
3. The maximum COBRA Coverage period for an Employee or Dependent who elects COBRA immediately after his or her maximum quarterly self-pay period has expired will be reduced by the number of Months of subsidized COBRA Coverage elected under the postponement option.
4. An Employee who does not satisfy the ARRA's eligibility criteria for the COBRA subsidy will still be eligible to make a quarterly self-payment for that Benefit Quarter or a non-subsidized COBRA self-payment. If necessary, the Fund Office will extend the grace period in order to give the Employee a reasonable amount of time to submit his self-payment.

5. An Employee will lose his right to a previously postponed quarterly self-pay period if his COBRA Coverage terminates before the end of a postponed quarter because a timely and correct COBRA payment was not made by him or on his behalf.
6. The postponement option described above applies only to coverage for the period July 1, 2009 Through December 31, 2009.

**AMENDMENT NO. 7**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Article 3 – Eligibility

Effective Date and Explanation of Revision:

- 1) Effective July 1, 2009, the amount an employee will be required to self-pay for the first benefit quarter after his period of subsidized COBRA coverage ends will be the lowest amount he would have owed for any self-pay quarter from the time he began eligibility under subsidized COBRA until the end of his subsidized COBRA period, or he can continue with COBRA. [Change applicable to Article 3, Section 2(a)(i)(F)(1)d-6, page 25.]
- 2) Effective July 1, 2009, COBRA coverage will include death, disability and dismemberment benefits. [Change applicable to Article 3, Section 9(d), page 46.]

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this 27th day of October 2009.

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JAMES M. SWEENEY

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JOHN E. KENNY, JR.

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STEVEN M. CISCO

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MICHAEL D. PIRAINO

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MARSHALL DOUGLAS

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DAVID SNETTEN

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DAVID FAGAN

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BRITT LIENAU

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JAMES J. McNALLY

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STEVE MICHAELS

**ARTICLE 3**

**ELIGIBILITY**

**Section 1. General.**

Employees shall become eligible for benefits if they perform covered work and sufficient contributions are made to the Fund on their behalf in accordance with the following provisions of this Article. In certain instances, eligibility may be based on self-contributions as specified in this Article.

**Section 2. Eligibility for Benefit Plan A.**

**(a) Quarterly Eligibility**

*(i) Bargaining Unit Employees*

The benefits provided for individuals who meet the eligibility requirements in this Section 2(a)(i) are set forth in the Appendix on the Schedule of Benefits for Plan A-1.

*(A) Definitions*

- (1) "Benefit Quarter" means a period of three consecutive Months beginning January 1, April 1, July 1, October 1.
- (2) "Contribution Quarter" means a period of three consecutive Months beginning August 1, November 1, February 1, May 1.

*(B) Initial Eligibility*

An Employee shall become eligible for benefits on the first day of a Benefit Quarter after the Fund Office has received contributions from an Employer or Employers for 300 hours of work during a Contribution Quarter, in accordance with the following schedule:

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

*(C) Initial Eligibility for Newly Organized Employees*

- (1) Employees of Newly Organized Employers who request immediate eligibility shall become eligible for benefits as set forth in this Section 2(a)(i)(C). A Newly Organized Employer is:
  - a. an Employer initially signatory to a new collective bargaining agreement with the Union; or
  - b. an Employer who is currently party to a collective bargaining agreement with the Union who:
    1. enters into an additional or amended collective bargaining agreement covering a unit of the Employer which is a newly organized employer with respect to such bargaining unit; or
    2. purchases or otherwise acquires an entity whose employees become covered by the collective bargaining agreement as a result of such acquisition. The Employer is a newly organized employer with respect to the employees of the acquired entity.
- (2) A Newly Organized Employer, in order to obtain immediate coverage on behalf of its Bargaining Unit Employees, must make a contribution in a uniform amount set by the Trustees for each Employee to the Fund. The contribution must be received prior to the commencement of the eligibility period and upon receipt of the contribution the Employees' coverage will be effective for an initial period of two Months. For Employees to be eligible for immediate coverage, they must not have had prior contributions made on their behalf.
- (3) In order to obtain continued Initial Eligibility coverage for a third Month under this Section, the Employee must work and the Newly Organized Employer must contribute to the Welfare Fund at least 100 hours during the first Month of eligibility on behalf of the eligible Employee, which contributions will be applicable to the third Month of coverage. Each Month thereafter, at least 100 hours must be contributed to maintain monthly eligibility.
- (4) The Initial Eligibility grace period during which an Employer may hire an Employee and obtain immediate eligibility shall be applicable only for a period of twelve months from the effective date of the collective bargaining agreement. All Employees hired after the twelve-month grace period will not be eligible for coverage under this Section and will only be permitted to establish eligibility under the Initial Eligibility requirements set forth in Section 2(a)(i)(B) above. The Employees that

are eligible to be added to the immediate coverage must be new hires and must not have had prior contributions made on their behalf to the Welfare Fund.

- (5) An employee of a Newly Organized Employer who had previous coverage under the Midwest Operating Engineers Welfare Fund, but whose coverage lapsed while an Employee of the Employer prior to being organized, and who continues in that employment as an Employee of the Newly Organized Employer shall be considered eligible for immediate coverage.
- (6) An Employee of a Newly Organized Employer will become a regular Bargaining Unit Employee once he has satisfied the initial eligibility rules set forth in Section 2(a)(i)(B) above.

*(D) Continuing Eligibility*

Eligibility shall continue in each Benefit Quarter as long as the Employee:

- (1) continues to meet the requirements set forth in Section 2(a)(i)(B) during each successive quarter; or
- (2) has a combined total of at least 1,200 hours in the applicable Contribution Quarter and the three Contribution Quarters immediately preceding it.

*(E) Work Credits for Eligible Disabled Employees*

If an Eligible Bargaining Unit Employee is receiving Weekly Disability Benefits pursuant to Article 9 or is receiving loss of income benefits under a Worker's Compensation or Occupational Disease Act, he will be entitled to credit for 40 hours per week for each of the first 17 weeks he receives such benefits toward Continuing Eligibility hereunder. A person whose eligibility is based on contributions made under an Owner/Relative clause of a collective bargaining agreement is not entitled to the credits described in this paragraph.

*(F) Continuing Eligibility Through Self-Payment*

*(1) Self-Payments for Plan A Coverage*

Once an Employee has met the Initial Eligibility requirements set forth in Section 2(a)(i)(B) above, he may make self-payments for up to a maximum of four consecutive Contribution Quarters to continue coverage, provided he is on the out-of-work list and available for work, under the following circumstances:

- a. If an Employee's eligibility is due to terminate because fewer than the needed number of hours as specified in Section 2(a)(i)(D) above were contributed on his behalf, the Employee may self-pay the balance of the remaining hours in an amount equal to the hourly rate specified by the Board of Trustees.
- b. If a disabled Employee's eligibility is due to terminate because fewer than the needed number of hours as specified in Section 2(a)(i)(D) above were contributed, including any hours credited on his behalf as specified in 2(a)(i)(E), the Employee may self-pay the balance of the remaining hours in an amount equal to the hourly rate specified by the Board of Trustees.
- c. Self-payments are due by the 15th day of the month preceding the Benefit Quarter for which coverage is desired; however, the Plan provides a grace period until the 30th day of the Benefit Quarter.
- d. *Postponement of Self-Pay Period*
  - 1. If an Employee is eligible to make a self-payment for the July 1, 2009 and/or the October 1, 2009 Benefit Quarters, and is also eligible to pay a lesser amount for COBRA Coverage because of the COBRA subsidy provided through the American Recovery and Reinvestment Act of 2009 (ARRA), the Employee's quarterly self-payment period will be postponed until after his subsidized COBRA Coverage period ends. The amount the Employee will be required to self-pay for a previously postponed Benefit Quarter will be the amount he would have paid for the postponed quarter, or the amount otherwise due for the current Benefit Quarter, whichever is less.
  - 2. The provisions set forth in No. 1 above will not apply to an Employee receiving Weekly Disability Benefits who wants to retain those benefits, or to an Employee who wants to retain his Death Benefit.
  - 3. The maximum COBRA Coverage period for an Employee or Dependent who elects COBRA immediately after his or her maximum quarterly self-pay period has expired will be reduced by the number of Months of subsidized COBRA Coverage elected under the postponement option.
  - 4. An Employee who does not satisfy the ARRA's eligibility criteria for the COBRA subsidy will still be eligible to make a quarterly self-payment for that Benefit Quarter or a non-subsidized

COBRA self-payment. If necessary, the Fund Office will extend the grace period in order to give the Employee a reasonable amount of time to submit his self-payment.

5. An Employee will lose his right to a previously postponed quarterly self-pay period if his COBRA Coverage terminates before the end of a postponed quarter because a timely and correct COBRA payment was not made by him or on his behalf.
6. ~~The postponement option described above applies only to coverage for the period July 1, 2009 Through December 31, 2009.~~ The amount the Employee will be required to self-pay for the first Benefit Quarter after his period of subsidized COBRA Coverage ends will be the lowest amount he would have owed for any self-pay quarter from the time he began eligibility under subsidized COBRA until the end of his subsidized COBRA period, or he can continue with COBRA.

*(2) Self-Payments for Plan C Coverage*

Once an Employee has met the Initial Eligibility requirements set forth in Section 2(a)(i)(B) above, he may decline to make self-payments for Plan A coverage and instead make self-payments for up to a maximum of four consecutive Contribution Quarters for Plan C coverage, provided he is on the out-of-work list and available for work. Plan C benefits are set forth in the Appendix on the Schedule of Benefits for Plan B-1. The Employee may elect to continue eligibility for himself and/or his Eligible Dependents. The following rules apply to Plan C self-payments and coverage:

- a. If an Employee's eligibility is due to terminate because fewer than the needed number of hours as specified in Section 2(a)(i)(D) above were contributed on his behalf, the Employee may self-pay the balance of the remaining hours in an amount equal to the hourly rate specified by the Board of Trustees.
- b. If a disabled Employee's eligibility is due to terminate because fewer than the needed number of hours as specified in Section 2(a)(i)(D) above were contributed, including any hours credited on his behalf as specified in 2(a)(i)(E), the Employee may self-pay the balance of the remaining hours in an amount equal to the hourly rate specified by the Board of Trustees.

- c. Self-payments are due by the 15th day of the month preceding the Benefit Quarter for which coverage is desired; however, the Plan provides a grace period until the 30th day of the Benefit Quarter.
- d. If an Employee initially elects to make self-payments for Plan A, he will be permitted to drop down to Plan C during the same self-payment period. He cannot go up from Plan C to Plan A for any remaining Eligibility Quarters during that same self-pay period.
- e. The Employee's maximum allowable self-pay period of four consecutive Contribution Quarters does not start over if he drops to Plan C coverage.
- f. Amounts applied to a person's deductibles, Maximum Benefits and other benefit accumulations while he was covered under Plan A will carry over and be applied to his Plan C deductible and benefit accumulations, and vice versa.

*(G) Employee Termination of Eligibility for Plan A Benefits*

Employee eligibility for Plan A benefits shall terminate upon the earliest of the following dates:

- (1) at the end of the last day of the Benefit Quarter for which the Continuing Eligibility requirements have been met;
- (2) when any self-payment is due and unpaid; or.
- (3) the date of the Employee's death.

*(H) Reinstatement*

An Employee whose eligibility has been terminated but who returns to work shall become reinstated once he satisfies the Initial Eligibility requirements set forth in Section 2(a)(i)(B) above.

*(I) Dependent Eligibility*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Employee's eligibility is effective or on the date the Employee acquires the Eligible Dependent, whichever is later.

*(J) Dependent Termination of Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- (1) the end of the Benefit Quarter in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;

- (2) the date the Employee's coverage terminates, except as stated in Sections 2(a)(i)(K) and 2(a)(i)(L) below; or
- (3) the date of the Dependent's death.

*(K) Termination of Dependent Coverage Following the Death of the Employee*

In the event of an Employee's death, and unless the Dependent elects to make self-payments for extended survivor coverage as set forth in the Section 2(a)(i)(L) below, coverage for his spouse and Dependent children will continue until the earliest of the following dates:

- (1) the last day of the Benefit Quarter for which the Employee had satisfied the Continuing Eligibility requirements; or
- (2) the date the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2.

*(L) Survivor Eligibility and Benefits*

- (1) Surviving Dependent spouses of deceased Eligible Employees whose eligibility is due to terminate may elect to continue coverage by making self-payments at the monthly rate specified by the Board of Trustees. The surviving spouse may continue coverage for herself and all Eligible Dependent children who were covered under the Plan on the day before the Employee's death. To be eligible, the following must apply:
  - a. the Employee must have been eligible under this Plan at the time of his death, and
  - b. the Employee must have been eligible under this Plan for at least ten years (40 Benefit Quarters).
- (2) A surviving Dependent spouse's eligibility will terminate at the end of the Month in which the first of the following events occurs:
  - a. the required self-payment is not made;
  - b. the spouse remarries;
  - c. the spouse dies;
  - d. the spouse becomes entitled to coverage under another group policy or plan, including Medicare; or
  - e. the spouse establishes permanent residence outside the continental limits of the United States.

- (3) A surviving Dependent child's eligibility will terminate at the end of the Month in which the first of the following events occurs:
  - a. the surviving Dependent spouse's eligibility terminates for any reason;
  - b. the child no longer meets the definition of Dependent child; or
  - c. the child becomes entitled to coverage under another group policy or plan, including Medicare.
- (4) COBRA Coverage, as described in this Article 3, is also available to qualified Dependent spouses and Dependent children, and can be elected in lieu of Survivor Benefits. Any period of COBRA Coverage will run concurrently with Survivor Benefits as described above. If the Dependent chooses Survivor Benefits and it ends before the expiration of 36-months from the death of the Employee, the Dependent may elect COBRA for the balance of the 36-month period.

(ii) *City of Chicago Employees*

The benefits provided for individuals who meet the eligibility requirements in this Section 2(a)(ii) are set forth in the Appendix on the Schedule of Benefits for Plan A-2.

In accordance with a collective bargaining agreement between the City of Chicago and the Union, employees who were previously covered under this Plan but who would otherwise have lost such coverage when they became employed by the City of Chicago are permitted to make quarterly flat-rate contributions to the Fund for supplemental health benefits. The amount of the required quarterly contribution is determined by the Trustees. In order to be eligible for benefits from this Fund, the Employee must be employed by the City of Chicago and must elect and be eligible for healthcare benefits through the City of Chicago.

(A) *Initial Eligibility*

An Employee shall become eligible for Plan A on the first day of the Benefit Quarter for which he makes the required contribution to the Fund.

(B) *Continuing Eligibility*

Eligibility will be continued as long as the Employee makes the required contribution to the Fund and maintains his group coverage through the City of Chicago.

*(C) Employee Termination of Eligibility*

Employee eligibility for Plan A benefits shall terminate upon the earliest of the following dates:

- (1) at the end of the last day of the Benefit Quarter for which the Employee made the required contribution to the Plan;
- (2) at the end of the Benefit Quarter preceding the Benefit Quarter for which the Employee first fails to maintain his group coverage through the City of Chicago; or
- (3) the date of the Employee's death.

*(D) Reinstatement*

If the Employee's eligibility terminates it cannot be reinstated.

*(E) Dependent Eligibility*

*(1) Initial Eligibility for Dependents*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Employee's eligibility is effective or on the date the Employee acquires the Eligible Dependent, whichever is later.

*(2) Dependent Termination of Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- a. the end of the Benefit Quarter in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- b. the date the Employee's coverage terminates, except that in the event of the Employee's death, the Dependent's eligibility will terminate on the last day of the Benefit Quarter for which the Employee had satisfied the Continuing Eligibility requirements; or
- c. the date of the Dependent's death.

**(b) Monthly Eligibility**

*(i) Non-Bargaining Unit Employees*

The benefits provided for individuals who meet the eligibility requirements in this Section 2(b)(i) are set forth in the Appendix on the Schedule of Benefits for Plan A-3.

(A) *Initial Eligibility*

The Initial Eligibility date for a Non-Bargaining Unit Employee shall be the first day of the Month following the Month in which his employment with the Contributing Employer begins.

(B) *Continuing Eligibility*

Continuing Eligibility will be determined on a Month-to-Month basis as long as the Employee continues in the employ of the Contributing Employer and the Employer makes the required monthly contribution to the Fund on his behalf. The amount of the required monthly contribution is established by the Trustees and set forth in the Employer's participation agreement with the Trustees.

(C) *Declining Coverage*

The terms of the participation agreement allow Non-Bargaining Unit Employees to decline eligibility for himself and/or his Dependent(s), and to enroll in the Plan at a later date. Coverage may only be declined and late enrollment is only allowable if the Employee is covered under another group health plan (including Medicare, Medicaid or a State Children's Health Insurance Program (SCHIP)) or health insurance, subject to the following rules:

- (1) The Employee must complete and sign a waiver form, and provide proof of the other group health plan or health insurance coverage that is satisfactory to the Administrative Manager within 60 days of declining Plan eligibility.
- (2) If an Employee declines eligibility for himself or for his Dependent(s), including his spouse, because of other group health plan or health insurance coverage, the Employee may in the future enroll himself and his Dependents in the Plan, provided that the Employee requests enrollment within 60 days after the Employee's other coverage ends due to the exhaustion of the COBRA continuation maximum period of coverage, the termination of employer contributions for coverage in the other plan, or the loss of eligibility for Medicaid or SCHIP coverage, or the loss of eligibility in such other plan due to divorce, legal separation, death, termination of employment or reduction in hours. In addition, if the Employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the Employee may enroll himself and his Dependent(s), provided that the Employee requests enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

*(D) Self-Payments*

Non-Bargaining Unit Employees may not make self-payments to the Fund, other than COBRA payments, to continue their eligibility.

*(E) Employee Termination of Eligibility for Plan A Benefits*

Eligibility for a Non-Bargaining Unit Employee shall terminate upon the earliest of the following dates:

- (1) the last day of the Month for which the Employer made the required contribution to the Plan;
- (2) the last day of the Month in which his employment with the Employer terminates; or
- (3) the date of the Employee's death.

*(F) Dependent Eligibility*

*(1) Initial Eligibility for Dependents*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the later of the following dates:

- a. the date the Employee's eligibility is effective;
- b. the date the Employee acquires the Eligible Dependent; or
- c. subject to the provisions of Section 2(b)(i)(C) above, if the Employee initially declined coverage for himself and the dependent, on the date the Employee subsequently enrolls the Eligibility Dependent.

*(2) Termination of Dependent Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- a. the end of the Month in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- b. the date the Employee's coverage terminates, except that in the event of the Employee's death, the Dependent's eligibility will terminate on the last day of the Benefit Quarter for which the Employee had satisfied the Continuing Eligibility requirements; or
- c. the date of the Dependent's death.

(ii) *Staff Employees*

The benefits provided for individuals who meet the eligibility requirements in this Section 2(b)(ii) are set forth in the Appendix on the Schedule of Benefits for Plan A-4.

(A) *Initial Eligibility*

The Initial Eligibility date for a Staff Employee shall be the first day of the Month following the Month in which his employment with the Contributing Employer begins.

(B) *Continuing Eligibility*

Continuing Eligibility for a Staff Employee will be determined on a Month-to-Month basis as long as the Employer makes the required monthly contribution to the Fund on his behalf. The amount of the required monthly contribution is established by the Trustees and set forth in the Contributing Employer's participation agreement with the Trustees.

(C) *Eligibility Credits for Eligible Disabled Employees*

If an Eligible Staff Employee is receiving Weekly Disability Benefits pursuant to Article 9 or is receiving loss of income benefits under a Worker's Compensation or Occupational Disease Act, he will be entitled to credit for up to four Months of eligibility toward Continuing Eligibility hereunder. The first monthly credit will be for the Month following the Month in which he becomes entitled to Weekly Disability Benefits or loss of income benefits due to a work-related Disability.

(D) *Self-Payments*

Staff Employees may not make self-payments to the Fund, other than COBRA payments, to continue their eligibility.

(E) *Employee Termination of Eligibility for Plan A Benefits*

Eligibility for a Staff Employee shall terminate upon the earliest of the following dates:

- (1) the last day of the Month during which the Employee's employment terminates;
- (2) the last day of the Month for which the Employer makes the required contribution to the Fund; or
- (3) the date of the Employee's death.

*(F) Dependent Eligibility*

*(1) Initial Eligibility for Dependents*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Employee's eligibility is effective or on the date the Employee acquires the Eligible Dependent, whichever is later.

*(2) Dependent Termination of Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- a. the end of the Month in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- b. the date the Employee's coverage terminates, except as stated in Sections 2(a)(i)(K) and 2(a)(i)(L) above; or
- c. the date of the Dependent's death.

*(iii) Owner/Relatives*

The benefits provided for individuals who meet the eligibility requirements in this Section 2(b)(iii) are set forth in the Appendix on the Schedule of Benefits for Plan A-4.

*(A) Initial Eligibility*

Initial Eligibility for an Owner/Relative shall be the first day of the Month for which the Employer makes the required contribution to the Fund.

*(B) Continuing Eligibility*

Continuing Eligibility will be determined on a Month-to-Month basis as long as the Employer makes the required monthly contribution to the Fund on his behalf. The amount of the required monthly contribution is established by the Trustees and set forth in the Employer's participation agreement with the Trustees.

*(C) Self-Payments*

Owner/Relatives may not make self-payments to the Fund.

*(D) Employee Termination of Eligibility for Plan A Benefits*

An Owner/Relative's eligibility for Plan A benefits shall terminate upon the earliest of the following dates:

- (1) at the end of the last day of the Month for which the Contributing Employer made the required contribution to the Plan;
- (2) the last day of the Month in which his employment with the Employer terminates;
- (3) the last day of the Month before the Month in which the Employer is no longer signatory to a participation agreement allowing contributions to be made to the Plan; or
- (4) the date of the Employee's death.

*(E) Dependent Eligibility*

*(1) Initial Eligibility for Dependents*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Owner/Relative's eligibility is effective or on the date the Owner/Relative acquires the Eligible Dependent, whichever is later.

*(2) Termination of Dependent Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- a. the end of the Month in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- b. the date the Employee's coverage terminates, except as stated in Sections 2(a)(i)(K) and 2(a)(i)(L) above; or
- c. the date of the Dependent's death.

*(iv) Municipalities*

The benefits provided for individuals who meet the eligibility requirements in this Section 2(b)(iv) are set forth in the Appendix on the Schedule of Benefits for Plan A-5.

*(A) Initial Eligibility*

The Initial Eligibility date for a Municipality Employee shall be the first day of the Month in which his employment with the Contributing Employer begins.

*(B) Continuing Eligibility*

Continuing Eligibility will be determined on a Month-to-Month basis as long as the Employer makes the required monthly contribution to the Fund on his behalf. The amount of the required monthly contribution is established by the Trustees and set forth in the Employer's participation agreement with the Trustees.

*(C) Self-Payments*

Municipality Employees may not make self-payments to the Fund, other than COBRA payments, to continue their eligibility.

*(D) Employee Termination of Eligibility for Plan A Benefits*

Eligibility for a Municipality Employee shall terminate upon the earliest of the following dates:

- (1) the last day of the Month during which the Employee's employment terminates;
- (2) the last day of the Month for which the Employer makes the required contribution to the Fund; or
- (3) the date of the Employee's death.

*(E) Dependent Eligibility*

*(1) Initial Eligibility for Dependents*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Employee's eligibility is effective or on the date the Employee acquires the Eligible Dependent, whichever is later.

*(2) Termination of Dependent Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- a. the end of the Month in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- b. the date the Employee's coverage terminates, except that in the event of the Employee's death, the Dependent's eligibility will terminate on the last day of the Month for which the Employee had satisfied the Continuing Eligibility requirements; or
- c. the date of the Dependent's death.

### **Section 3. Eligibility for Employees in Plan B.**

The Plan provides a level of benefit coverage called “Plan B” for certain active Employees (sometimes referred to as “plantmen”) whose Employers have entered into a collective bargaining agreement with the Union under which the Employer makes contributions to the Plan for the benefits provided under the Plan B Schedule of Benefits. The amount of the required monthly contribution is determined by the Trustees.

#### **(a) Monthly Eligibility**

The benefits provided for individuals who meet the eligibility requirements in this Section 3(a) are set forth in the Appendix on the Schedule of Benefits for Plan B-1.

##### *(i) Initial Eligibility*

An Employee shall become eligible for Plan B on the first day of the Month following 31 days of employment with the Contributing Employer.

##### *(ii) Continuing Eligibility*

Continuing Eligibility will be determined on a Month-to-Month basis as long as the Employer makes the required monthly contribution to the Fund on his behalf. The amount of the required monthly contribution is established by the Trustees and set forth in the Contributing Employer’s collective bargaining agreement with the Trustees.

##### *(iii) Self-Payments*

Plan B Employees may not make self-payments to the Fund, other than COBRA payments, to continue their eligibility. However, the Employee may make up to three monthly payments each Calendar Year to the Employer so that the Employer will make contributions to the Fund on the Employee’s behalf for coverage during January, February and March.

##### *(iv) Employee Termination of Eligibility for Plan B*

Eligibility for a Plan B Employee shall terminate upon the earliest of the following dates:

- (A) the last day of the Month during which the Employee’s employment terminates;
- (B) the last day of the Month for which the Employer makes the required contribution to the Fund; or
- (C) the date of the Employee’s death.

(v) *Dependent Eligibility*

(A) *Dependent Eligibility*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Employee's eligibility is effective or on the date the Employee acquires the Eligible Dependent, whichever is later.

(B) *Dependent Termination of Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- (1) the end of the Month in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- (2) the date the Employee's coverage terminates, except that in the event of the Employee's death, the Dependent's eligibility will terminate on the last day of the Month for which the Employee had satisfied the Continuing Eligibility requirements; or
- (3) the date of the Dependent's death.

**Section 4. Eligibility for Employees in Plan D.**

The Plan provides a level of benefit coverage called "Plan D" for active Employees whose Employers make contributions to the Plan for Dental Benefits only. The amount of the required monthly contribution is determined by the Trustees.

The benefits provided for individuals who meet the eligibility requirements in this Section 4 are set forth in the Appendix on the Schedule of Benefits for Plan D-1.

**(a) Initial Eligibility**

An Employee shall become eligible for Plan D on the first day of the Month following the date his employment with the Contributing Employer begins.

**(b) Continuing Eligibility**

Continuing Eligibility will be determined on a Month-to-Month basis as long as the Employer makes the required monthly contribution to the Fund on his behalf. The amount of the required monthly contribution is established by the Trustees.

**(c) Self-Payments**

Plan D Employees may not make self-payments to the Fund, other than COBRA payments, to continue their eligibility.

**(d) Employee Termination of Eligibility for Plan D**

Eligibility for a Plan D Employee shall terminate upon the earliest of the following dates:

- (i) the last day of the Month during which the Employee's employment terminates;
- (ii) the last day of the Month for which the Employer makes the required contribution to the Fund; or
- (iii) the date of the Employee's death.

**(e) Dependent Eligibility**

*(i) Initial Eligibility for Dependents*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Employee's eligibility is effective or on the date the Employee acquires the Eligible Dependent, whichever is later.

*(ii) Termination of Dependent Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- (A) the end of the Month in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- (B) the date the Employee's coverage terminates, except that in the event of the Employee's death, the Dependent's eligibility will terminate on the last day of the Month for which the Employee had satisfied the Continuing Eligibility requirements; or
- (D) the date of the Dependent's death.

**Section 5. Eligibility for Employees in Plan E.**

The Plan provides a level of benefit coverage called "Plan E" for active Employees whose employment is covered by a collective bargaining agreement between the Illinois Landscape Contractors Bargaining Association and the Union. The amount of the required monthly contribution is determined by the Trustees.

The benefits provided for individuals who meet the eligibility requirements in this Section 5 are set forth in the Appendix on the Schedule of Benefits for Plan E-1.

**(a) Initial Eligibility**

An Employee shall become eligible for Plan E on the first day of the Month following 31 days of employment with the Contributing Employer.

**(b) Continuing Eligibility**

Continuing Eligibility will be determined on a Month-to-Month basis as long as the Employer makes the required monthly contribution to the Fund on his behalf. The amount of the required monthly contribution is established by the Trustees.

**(c) Self-Payments**

Plan E Employees may not make self-payments to the Fund, other than COBRA payments, to continue their eligibility.

**(d) Employee Termination of Eligibility for Plan E**

Eligibility for a Plan E Employee shall terminate upon the earliest of the following dates:

- (i) the last day of the Month during which the Employee's employment terminates;
- (ii) the last day of the Month for which the Employer makes the required contribution to the Fund; or
- (iii) the date of the Employee's death.

**(f) Dependent Eligibility**

*(i) Initial Eligibility for Dependents*

A dependent who meets the definition of an Eligible Dependent shall become eligible on the date the Employee's eligibility is effective or on the date the Employee acquires the Eligible Dependent, whichever is later.

*(ii) Termination of Dependent Eligibility*

Dependent eligibility shall terminate upon the earlier of the following dates:

- (A) the end of the Month in which the person ceases to be an Eligible Dependent as defined in Section 18 of Article 2;
- (B) the date the Employee's coverage terminates, except that in the event of the Employee's death, the Dependent's eligibility will terminate on the last day of the Month for which the Employee had satisfied the Continuing Eligibility requirements; or
- (C) the date of the Dependent's death.

**Section 6. Reciprocity.**

- (a) If an Employee of a Contributing Employer is required by such Employer to temporarily perform work outside the geographical jurisdiction of the Union, such Employee will

continue to be eligible as though employed within the geographical jurisdiction of the Union, if the Employee signs an authorization form provided by the Fund, and if the Employer has made the required Contributions to the Fund on the Employee's behalf during the period of outside employment. Only contributions made in accordance with the specific Reciprocity Agreement can be accepted under this Section.

- (b) In the case of an Employee on whose behalf Contributions are transmitted to the Trust Fund by a cooperating welfare fund, under a reciprocal agreement entered into, as authorized by the Board of Trustees, hours of work for the purpose of continued eligibility hereunder shall be credited to such an Employee as hereafter provided that the total sum of Employer Contributions transmitted to the Fund Office on behalf of such an Employee, for a specified Contribution Quarter, shall be divided by the hourly contribution rate in the Heavy and Highway Agreement for District 1. The quotient shall be the number of hours of work to be credited to such an Employee for the specified Contribution Quarter.
- (c) Based on the above provisions of this Section 6, Continuing Eligibility of any such Employee shall then be determined in accordance with this Article 3.

### **Section 7. Continuation of Coverage During Leave of Absence (FMLA)**

Eligible Employees may be able to continue medical benefits under the Family and Medical Leave Act of 1993 (FMLA). Only Eligible Employees of Contributing Employers who are obligated to comply with the FMLA are eligible for this continuation.

#### **(a) Continuing Health Coverage**

The Contributing Employer must:

- (i) notify the Administrative Manager when a FMLA leave is granted; and
- (ii) if the Employee's eligibility is determined on a quarterly basis, make contributions for each Month based on the average monthly contributions made on the Employee's behalf over the last five years; or
- (iii) if the Employee's eligibility is determined on a monthly basis, make the required payments on a timely basis.

#### **(b) Maintenance of Health Benefit**

A Contributing Employer must continue to make contributions for an Eligible Employee while he is on FMLA leave. Notice must be made on the remittance form and the contributions must be sent to the Administrative Manager.

**(c) Termination of the FMLA Obligation to Maintain Health Care Coverage**

The Fund's obligation to maintain health care coverage during a FMLA leave ends on the earliest of the following dates:

- (i) when an Employee returns to work;
- (ii) when twelve (12) weeks of FMLA leave ends; or
- (iii) when the Employer ceases to make contributions to the Fund to continue the Employee's coverage.

**(d) Interaction with COBRA**

The Employee's FMLA leave period will run concurrently with his COBRA Coverage period and any period during which his eligibility is extended due to Disability.

**(e) Disputes over Eligibility and Coverage**

All disputes over an Eligible Employee's eligibility under FMLA are between the Employee and Contributing Employer. Benefits will be suspended pending resolution of the dispute. The Trustees will have no direct role in resolving such a dispute.

**Section 8. Military Service**

**(a) Eligibility Freeze During Active Duty**

If an Eligible Employee leaves employment with a Contributing Employer to serve in the U.S. military, his accumulated eligibility may either be frozen during his military service or used to continue eligibility for his Dependents. The eligibility freeze is the default option. Under a freeze the Employee's accumulated eligibility, if any, will be frozen until he returns to work with the Employer. During the freeze period, neither the Employee nor his Dependents will be eligible for Plan benefits unless the Employee elects to make self-payments as described in Section 8(b)(ii)(A) below. After the Employee returns to covered employment, the eligibility he accumulated before his military duty period will be reinstated. An Employee may decline a freeze by contacting the Administrative Manager and authorizing use of his accumulated eligibility to provide eligibility for his Dependents. After that eligibility period ends, the Employee may elect to continue coverage for his Dependents by making make self-payments as described in Section 8(b)(ii)(A).

**(b) Uniformed Services Employment and Reemployment Rights (USERRA)**

Eligible Employees and Dependents may be able to continue medical benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

(i) *Definitions for Purposes of this Section 8 Only*

- (A) “Health Coverage” means Hospital, surgical, medical, or prescription drug coverage provided under the Plan. Health Coverage is subject to change as a result of Plan modifications.
- (B) “USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such Act and any interpretive regulations or rulings).
- (C) “Service in the uniformed services” means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.
- (D) “Uniformed services” means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

(ii) *Continuation of Group Health Coverage*

- (A) For an Employee and his eligible Dependents: If Health Coverage ends because of an Employee’s service in the uniformed services, an Employee or Dependent may elect to continue such Health Coverage until 24 consecutive months after coverage ended. This 24-month period will run concurrently with the Employee’s COBRA Coverage period.
- (B) To continue coverage, an Employee or his Dependent must pay the required contribution amount unless service in the uniformed service is for fewer than 31 days, in which case an Employee must pay his share, if any, of the premium. The Administrative Manager will inform an Employee or his Dependent of procedures to pay premiums.

(iii) *Other Continuation Provisions*

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

(iv) *Reemployment Following Uniformed Service*

Following discharge from such service, an Employee may be eligible to apply for reemployment with his former Contributing Employer in accord with USERRA. Such reemployment includes the right to elect reinstatement in any then existing health coverage provided by the Contributing Employer, and if the returning Employee declined to make self-payments to continue his coverage during his military leave, he may elect to make such self-payments upon his reemployment.

(v) *End of Continuation*

A covered person's continued Health Coverage will end at midnight on the earliest of:

- (A) the day an Employee's former Contributing Employer ceases to provide any group health plan to any Employee;
- (B) the day premium is due and unpaid;
- (C) the day a covered person again becomes covered under the Plan; or
- (D) the day Health Coverage has been continued for the period of time provided in Section 8(b)(ii)(A) above (or any longer period provided in the Plan).

(vi) *In the Event of Conflicting Provisions*

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by an Employee's Contributing Employer or former Contributing Employer, shall apply.

**Section 9. COBRA Coverage.**

Pursuant to the provisions of the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") and regulations issued thereunder, the Fund shall offer Qualified Beneficiaries the opportunity for a temporary extension of health coverage ("COBRA Coverage") on a self-pay basis upon the occurrence of a Qualifying Event as defined below. ~~COBRA Coverage only applies to the health coverage (including dental benefits) available under the Plan, and shall not include continuation of coverage for death benefits, accidental dismemberment coverage or weekly disability benefits.~~ The following COBRA provisions shall be interpreted in accordance with the developing regulatory and case law under COBRA, since it is the intent of the Trustees, in their capacity as sponsor of this Plan, to meet the requirements of COBRA.

**(a) Definition of Qualified Beneficiary**

- (i) A "Qualified Beneficiary" is any person who, as of the day before a Qualifying Event, is an Eligible Employee covered under the Plan as of such day, the spouse of the Eligible Employee, who is covered as an Eligible Dependent under the Plan

as of such day, or a child of the Eligible Employee, who is covered as an Eligible Dependent under the Plan as of such day.

- (ii) A Dependent born to the Employee, adopted by the Employee or placed for adoption with the Employee during a period of COBRA Coverage is also a Qualified Beneficiary.

**(b) Qualifying Events**

Any of the following shall be considered to be a Qualifying Event if it would cause the Qualified Beneficiary to lose coverage under the Plan were it not for the continuation of coverage provisions of this Section.

*(i) Qualifying Events for an Eligible Employee*

A Qualified Beneficiary who is an Eligible Employee shall have the right to choose COBRA Coverage for himself if he loses coverage under the Plan because of the termination of his employment (for reasons other than gross misconduct) or a reduction in hours of employment, which includes, but is not limited to, lay-off, strike, Disability, medical leave of absence or retirement.

*(ii) Qualifying Events for Eligible Dependents (Spouse and Children)*

(A) A Qualified Beneficiary who is the Dependent spouse of an Eligible Employee shall have the right to choose COBRA Coverage for himself if he loses coverage under the Plan for any of the following reasons:

- (1) the death of the Eligible Employee;
- (2) the termination of the Eligible Employee's employment (for reasons other than gross misconduct) or reduction of the Eligible Employee's hours of employment;
- (3) divorce or legal separation from the Eligible Employee; or
- (4) the Eligible Employee's becoming entitled to Medicare.

(B) A Qualified Beneficiary who is a Dependent child of an Eligible Employee, shall have the right to choose COBRA Coverage if his coverage under the Plan is lost for any of the following reasons:

- (1) the death of the Eligible Employee;
- (2) the termination of the Eligible Employee's employment (for reasons other than gross misconduct) or reduction of the Eligible Employee's hours of employment;
- (3) divorce or legal separation of the Eligible Employee;

- (4) the Eligible Employee's becoming entitled to Medicare; or
- (5) he ceases to be an Eligible Dependent as defined under this Plan.

**(c) Notice and Election of COBRA Coverage**

- (i) In order to qualify for COBRA Coverage, the Qualified Beneficiary has the responsibility to inform the Administrative Manager at the Fund Office immediately after a divorce, legal separation, or if a child ceases to satisfy the definition of "Eligible Dependent child" in the Plan. If the Qualified Beneficiary does not report such event to the Administrative Manager within 60 days after loss of coverage due to the event, COBRA Coverage will not be available.
- (ii) It is the responsibility of the Eligible Employee's Contributing Employer to notify the Administrative Manager within 45 days of the Eligible Employee's death, termination of employment, or reduction in hours which causes a loss of medical benefits under the Plan, or the Eligible Employee's entitlement to Medicare. However, the Eligible Employee or other family member should notify the Administrative Manager if any of these Qualifying Events occurs in order to assure timely notification of eligibility for, and processing of, an election of COBRA Coverage.
- (iii) Each Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act, to have been disabled at the time, or within 60 days, of a Qualifying Event must notify the Administrative Manager at the Fund Office of such determination within 60 days after the determination. Each Qualified Beneficiary who has been determined to have been disabled at the time of a Qualifying Event must notify the Administrative Manager at the Fund Office within 30 days of the date of any final determination under Title II or Title XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.
- (iv) When the Administrative Manager is notified that a Qualifying Event has occurred, the Administrative Manager will notify all Qualified Beneficiaries within 14 days of their right to choose COBRA Coverage by submitting the appropriate election. Notification to a Qualified Beneficiary who is a spouse of an Eligible Employee is treated as notification to all other Qualified Beneficiaries residing with that person at the time notification is made.
- (v) The Administrative Manager must receive the election at least 60 days from the later of the date coverage terminated or will terminate under the Plan or the date of the notice advising of rights to COBRA Coverage. The Qualified Beneficiary does not have to show that he is insurable to choose COBRA Coverage. If the Qualified Beneficiary does not choose COBRA Coverage within the 60-day time limit, his coverage under the Plan will not be continued.

**(d) Benefits Available Under COBRA Coverage**

~~COBRA Coverage benefits are the same benefits to which the Qualified Beneficiary was entitled at the time his Qualifying Event occurred. However, COBRA Coverage does not include Death, Accidental Dismemberment or Weekly Disability Benefits, regardless of when or by whom COBRA Coverage is elected. COBRA Coverage benefits are the same benefits to which the Qualified Beneficiary was entitled at the time his Qualifying Event occurred, including Death, Accidental Dismemberment and Weekly Disability Benefits for Employees.~~

**(e) Cost of Coverage; Payment Due Dates**

- (i) Entitlement to COBRA Coverage shall be conditioned upon payment of monthly contributions determined annually by the Trustees, which shall not exceed 102% of the cost for providing health benefits to individuals in the same benefits selection situation as the Qualified Beneficiary. However, the Trustees, in their discretion, may charge an amount up to, but not exceeding 150% of the cost for providing health benefits to individuals in the same benefits selection situation as the Qualified Beneficiary during the 19th through the 29th Month of coverage for a Qualified Beneficiary who elects extended coverage because of Disability. The Administrative Manager will provide specific cost information to the Qualified Beneficiary along with notice of eligibility for COBRA Coverage.
- (ii) Contributions for the period of COBRA Coverage through the Month in which the election is made must be received by the Administrative Manager within 45 days after the date of the election. Contributions for each Month subsequent to the Month in which the election was made must be received by the Administrative Manager by the first of that Month, except that a 30-day grace period shall be provided.

**(f) Maximum Coverage Periods; Termination of COBRA Coverage**

*(i) Maximum Coverage Periods*

COBRA Coverage shall extend for the maximum periods set forth below, or until the occurrence of an event described in Section 9(g) below, if earlier.

- (A) Qualified Beneficiaries who are Eligible Dependents will be afforded the opportunity to continue health coverage for 36 Months after the Qualifying Event (commencing on the date coverage would otherwise terminate), except in the case where the Qualifying Event is the Eligible Employee's loss of coverage due to termination of employment or reduction in hours, in which case the COBRA Coverage period for all Qualified Beneficiaries (including the Eligible Employee) is 18 Months after the Qualifying Event. However, if a Qualified Beneficiary who is an Eligible Dependent is receiving COBRA

Coverage for the 18-Month period and another Qualifying Event occurs, e.g., the Eligible Employee dies, the Eligible Dependent is eligible to have COBRA Coverage extended to a total of 36 Months from the date of the first Qualifying Event.

- (B) In the case of a Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act, to have been disabled at the time or within 60 days of the Qualifying Event involving the Eligible Employee's loss of coverage due to termination of employment or reduction in hours, the maximum period of COBRA Coverage is extended from 18 Months to 29 Months, provided that the Qualified Beneficiary has provided the required notice of such determination to the Fund within the original COBRA continuation period of 18 Months. In addition, other family members who had elected COBRA Coverage can keep it for the extended period if they choose. In the event that the Qualified Beneficiary is finally determined under Title II or Title XVI of the Social Security Act to no longer be disabled, the period of extended COBRA Coverage beyond the 18 Months shall terminate at the end of the Month beginning at least 30 days after the date of the final determination that the Qualified Beneficiary no longer is disabled.

**(g) Termination of COBRA Coverage**

Regardless of which continuation period applies, a Qualified Beneficiary's COBRA Coverage shall terminate upon the occurrence of any of the following events:

- (i) The Contributing Employer ceases to maintain this Plan (that is, the Contributing Employer no longer has an obligation to contribute to the Fund for any Eligible Employees). The cessation of COBRA Coverage under this Plan pursuant to this paragraph does not alter any obligation a Contributing Employer may have to provide COBRA Coverage;
- (ii) The Qualified Beneficiary fails to make a required premium payment when due (including the 30-day grace period);
- (iii) The Qualified Beneficiary becomes covered under another group health plan which provides substantially similar benefits after the commencement of this COBRA Coverage, unless such health plan contains an exclusion or limitation with respect to a preexisting condition that such Qualified Beneficiary has; or
- (iv) The Qualified Beneficiary becomes entitled to Medicare.

**Section 10. Termination of Eligibility.**

**(a) Date and Time of Termination**

If an Employee or Dependent loses eligibility in accordance with the provisions set forth in this Article, the person's benefits will terminate at midnight on the specified date.

**(b) Termination of Plan**

In addition to the events set forth in this Article that will cause an Employee or Dependent to lose eligibility under this Plan, eligibility and coverage for all persons will cease on the date the Plan terminates.

**Section 11. Certification of Coverage.**

When an Eligible Employee's coverage under this Plan ends, the Fund shall provide such Employee and his Eligible Dependents with a certificate of coverage that indicates the period of time the person was covered under the Plan, and certain additional information that is required by federal law. The certificate will be sent by first class mail shortly after the individual's coverage under this Plan ends. If the individual elects COBRA Coverage, another certificate will be provided shortly after the COBRA Coverage ends. In addition, a certificate shall be provided upon receipt of a request for such certificate if that request is received by the Fund within two years after the later of the date coverage under this Plan ended or the date COBRA Coverage ended.

## AMENDMENT NO. 8

### TO THE HEALTH AND WELFARE PLAN OF THE MIDWEST OPERATING ENGINEERS WELFARE FUND AS RESTATED AND EFFECTIVE JANUARY 1, 2008

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

- Article 10 – Comprehensive Medical Expense Benefit
- Article 14 – Dental Expense Benefit
- Article 18 – General Plan Exclusions and Limitations

Effective Date and Explanation of Revision:

Effective January 1, 2008:

- 1) With respect to dental services covered under the Comprehensive Medical Expense Benefit, the Plan will cover treatment received within twelve months of an accidental injury to the teeth, regardless of whether the accident occurred while the person was covered under the Plan at the time of the accident.
- 2) With respect to dental services covered under the Dental Expense Benefit, procedures started prior to the person's effective date will only be excluded if they were started within six months before the person's effective date, and the provisions governing the Plan's pre-existing condition limitation will apply to this exclusion.
- 3) The Plan's exclusion for treatment resulting from the commission of a felony is revised so that it does not apply if the treatment is the result of an act of domestic violence or a medical condition (including both physical and mental health conditions).

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this 27th day of October, 2009.

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JAMES M. SWEENEY

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JOHN E. KENNY, JR.

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STEVEN M. CISCO

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MICHAEL D. PIRAINO

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MARSHALL DOUGLAS

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DAVID SNELTEN

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DAVID FAGAN

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BRITT LIENAU

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JAMES J. McNALLY

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STEVE MICHAELS

**ARTICLE 10**

**COMPREHENSIVE MEDICAL EXPENSE BENEFIT**

**Section 9. Exclusions and Limitations.**

- (o) Any operation or treatment for teeth and gums, except:
  - (i) tumors;
  - (ii) removal of a cyst certified by a Physician or Dentist to be Medically Necessary to be performed in a Hospital or freestanding surgical facility that has been pre-authorized by the Fund Office;
  - (iii) orthodontia, as set forth in Item (cc) of Section 8 of this Article 10; or
  - (iv) repair of Injury to sound natural teeth which occurs within twelve months of the accident.

**ARTICLE 14**

**DENTAL EXPENSE BENEFIT**

**Section 6. Exclusions and Limitations.**

- (a) any treatment or procedure (except orthodontia) that was incurred before the date the covered person's dental coverage began or after the person's coverage terminated. Also excluded is any treatment or procedure (except orthodontia) that began within six months before the person's Enrollment Date, subject to the creditable coverage rules and twelve-month limitation period as set forth in Article 10, Section 7, subparagraphs (b) and (c).

**ARTICLE 18**

**GENERAL PLAN EXCLUSIONS AND LIMITATIONS**

**Section 1. Conditions Governing Payment of Benefits.**

- (q) treatment of a condition or related condition that is a result of the commission of a felony, except as the result of an act of domestic violence or a medical condition (including both physical and mental health conditions); or a condition or related condition that is a result of war or any act of war, whether war is declared or undeclared;

**AMENDMENT NO. 9**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Article 2 – Definitions

Section 18 – Eligible Dependent, subparagraph (d)

Effective Date and Explanation of Revision:

Effective January 1, 2010 in compliance with Michelle’s Law, coverage will be extended for at least one year for a student who takes a medical leave of absence due to a serious illness or injury.

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this 27th day of October, 2009.

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JAMES M. SWEENEY

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JOHN E. KENNY, JR.

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STEVEN M. CISCO

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MICHAEL D. PIRAINO

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MARSHALL DOUGLAS

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DAVID SNELTEN

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DAVID FAGAN

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BRITT LIENAU

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JAMES J. McNALLY

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STEVE MICHAELS

## ARTICLE 2

### DEFINITIONS

#### **Section 18. Eligible Dependent.**

- (d) (i) full-time students, who were Eligible Dependents at the time they reached their 19th birthday, provided that they:
  - (A) have remained continuously eligible under the Plan;
  - (B) have not reached their 23rd birthday; and
  - (C) are dependent on the Employee for at least one-half of their support.
- (ii) Proof of full-time student status must be provided to the Administrative Manager every semester. The Trustees require documentation from the school registrar's office, which must bear the school seal.
- (iii) Eligibility ends on the last day of the Benefit Quarter (if eligibility is based on Contribution Quarters) or Month (if eligibility is determined on a Month-to-Month basis) in which the Dependent is last enrolled as a full-time student. However, a Dependent who is enrolled during a spring semester will remain continuously eligible between semesters if subsequently enrolled in the next fall semester. A Dependent child who no longer is a full-time student or otherwise no longer meets the Plan's definition of Dependent, as set forth in this Section 18, may elect COBRA Coverage as set forth in Article 3. A Dependent child who stops being continuously eligible because he is no longer a full-time student and who did not elect COBRA Coverage who subsequently re-enrolls as a full-time student must elect to make COBRA payments for the period of time he was not a full-time student to again be eligible under the Plan. Only one such exception to the requirement of maintaining continuous eligibility will be allowed during the Dependent's lifetime. The COBRA payment amount will be an amount equal to the then current monthly COBRA self-payment rate times the number of Months he was not eligible. The Dependent must provide written notice to the Fund Office of his election and make full payment within 30 days.
- (iv) The following provisions will apply to an Eligible Dependent child age 19 or over who takes a medical leave of absence from school on or after January 1, 2010.
  - (A) To the extent required by law, if an Eligible Dependent child age 19 or over is covered under the Plan as a full-time student immediately before the first day of a medically necessary leave (as defined in subparagraph (B) be-

low), then Plan coverage for that child will not terminate due to the leave until the earlier of:

- (1) The date that is one year after the first day of the medically necessary leave; or
  - (2) The date on which the child's coverage would otherwise terminate under the terms of the Plan. (This includes but is not limited to the child's attaining the disqualifying age, and the failure of the Employee to satisfy the Plan's eligibility requirements.)
- (B) For the purposes of this Section 18(d)(iv), a "medically necessary leave" means a leave of absence or any other change in enrollment of such child beginning on or after January 1, 2010 from an educational institution that commences while such child is suffering from a serious illness or injury, and is medically necessary, and causes the child to lose status as a full-time student for purposes of coverage under the terms of the Plan.
- (C) For Plan coverage to continue during a medically necessary leave, a treating physician of the Dependent child must provide written certification to the Plan that the Dependent child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) described is medically necessary. No coverage will be extended under this provision unless and until such notice is provided to the Fund Office. Plan coverage commences on the date such certification is received by the Plan, but will be retroactive to the date on which the medically necessary leave of absence began.
- (D) A Dependent child whose benefits are continued under a medically necessary leave shall be entitled to the same benefits as if the child continued to have full-time student status and was not on a medically necessary leave.
- (E) If coverage under the Plan changes, for example, from self-insured to insured, while a Dependent child is being covered pursuant to a medically necessary leave, then the provisions of this Section 18(d)(iv) shall apply to the changed coverage of the Dependent child for the remainder of the period of the medically necessary leave in the same manner as it would have applied to the previous coverage, provided the Plan continues to provide Dependent child coverage.

**AMENDMENT NO. 10**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Article 2 – Definitions

Effective Date and Explanation of Revision:

Effective January 1, 2009, the Plan will cover the services of a non-physician surgical assistant when the services would be covered had they been performed by a Physician. The maximum allowable charge for surgical assistance performed by a non-physician surgical assistant will be 17% of the allowable expense for the surgeon;

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this 27th day of October, 2009.

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JAMES M. SWEENEY

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JOHN E. KENNY, JR.

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STEVEN M. CISCO

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MICHAEL D. PIRAINO

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MARSHALL DOUGLAS

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DAVID SNELTEN

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DAVID FAGAN

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BRITT LIENAU

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JAMES J. McNALLY

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STEVE MICHAELS

**ARTICLE 2**

**DEFINITIONS**

**Section 25. Health Care Provider.**

- (m) Surgical Assistants (SA, CSA, etc.) when the services would be covered had they been performed by a Physician. The maximum allowable charge for surgical assistance performed by a non-physician surgical assistant will be 17% of the allowable expense for the surgeon;

**AMENDMENT NO. 11**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Appendix – Schedules A-1, A-2, A-3, A-4, A-5, A-6, B-1, D-1 and E-1

Effective Date and Explanation of Revision:

Effective January 1, 2009, the maximum benefit for physical and occupational therapy for congenital neurological diseases for dependent children is increased from \$3,000 to \$5,000 per calendar year.

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this 16th day of February, 2010.

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JAMES M. SWEENEY

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JOHN E. KENNY, JR.

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STEVEN M. CISCO

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MICHAEL D. PIRAINO

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BRITT LIENAU

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JAMES J. McNALLY

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STEVE MICHAELS

# **APPENDIX**

**Schedule of Benefits Plan A-1  
Quarterly Employees**

**Schedule of Benefits Plan A-2  
City of Chicago – Quarterly**

**Schedule of Benefits Plan A-3  
Non-bargaining Employees**

**Schedule of Benefits Plan A-4  
Staff, Owner/Operator**

**Schedule of Benefits Plan A-5  
Municipality – Monthly**

**Schedule of Benefits Plan A-6  
Retirees**

**Schedule of Benefits Plan B-1  
Plantsmen**

**Schedule of Benefits Plan D-1  
Dental only**

**Schedule of Benefits Plan E-1  
Landscapers**

**SCHEDULE OF BENEFITS – Plan A - 1**

**QUARTERLY EMPLOYEES  
Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Disability Benefits</b>	
<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for up to 52 weeks. Eligibility is credited with 40 hours a week for the first 17 weeks
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan A - 2**

**City of Chicago - Quarterly  
Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Disability Benefits</b>	
<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for first 30 days
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$7,500 member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan A - 3**

**Non - Bargaining Employees  
Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan A - 4**

Staff – Owner/Relatives

**Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90%- In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Disability Benefits</b>	
<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for up to 52 weeks <b>Staff</b> – eligibility is credited with 40 hours per week for the first 17 weeks <b>Owner/Relative</b> – pays monthly, no credit is applied toward eligibility
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan A - 5**

**Municipality - monthly  
Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only.</b> Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Disability Benefits</b>	
<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for first 30 days
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan A - 6**

**Retirees**

**Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$10,000 – Local 537 members only
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan B - 1**

**Plantsmen – monthly  
Comprehensive Medical Expense Benefits**

<b>Lifetime Maximum</b>	\$250,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$100
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$300
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	80% - In Network only
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	80% - In Network only Maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	80% - In Network only
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	80% - In Network only
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	80% - In Network only
<b>MRI and CT Scans</b>	100% - Medlink 80% - In Network Only
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	80% - In Network only
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	50% - In Network only
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	50% - In Network only calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	50% - In Network only calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	50% - In Network only calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 only. Training needs to be prescribed by a covered provider.	50% - In Network only lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	80% - In Network only
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% - In Network only lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 80% - In Network only
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	70% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80% - In Network only
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	80% - In Network only lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	80% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% - In Network only lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	80% - In Network only Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 80% - In Network only

**Prescription Drug Program**

<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$7,500 per individual
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

**SCHEDULE OF BENEFITS – Plan D - 1**

**Dental Only  
Dental Expense Benefits**

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000

**SCHEDULE OF BENEFITS – Plan E - 1**

**Landscapers**

**Comprehensive Medical Expense Benefits**

<b>Lifetime Maximum</b>	\$350,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$100
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$300
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 70% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 70% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 70% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 70% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 70% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 70% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 70% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 70% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 70% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 70% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 70% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 70% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 70% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 70%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	70% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	70%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	70% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 70% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 70% - Out of Network

**Mental Illness and Substance Abuse**

<b>Mental Illness and Substance Abuse – prior authorizations from MAP provider is required</b>	
Inpatient Care	\$50 deductible 90% lifetime maximum 30 days
Outpatient Care	\$50 deductible 90% lifetime maximum 60 visits

**Prescription Drug Program**

<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 day supply Generic \$5 co-pay – 30 day supply annual maximum \$10,000 per individual
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

**Dental Benefits**

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> )	50% lifetime maximum \$750

**Death Benefit**

<b>Death Benefit</b>	\$1,000 – member
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**Family Supplemental Benefit**

<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$500
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**AMENDMENT NO. 12**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Article 10 – Comprehensive Medical Expense Benefit

Appendix – Schedules A-1, A-2, A-3, A-4, A-5, A-6, B-1, D-1 and E-1

Effective Date and Explanation of Revision:

Effective June 1, 2009, oral apnea appliances provided by dentists will be covered under the medical portion of the plan. The maximum benefit payable by the Plan for all apnea appliances (oral and C-Pap-type) is \$3,000 every five years, and the Plan will only cover the replacement of an existing appliance every five years. All appliances must be pre-certified by the Plan’s Case Manager.

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this 16th day of February, 2010.

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JAMES M. SWEENEY

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JOHN E. KENNY, JR.

\_\_\_\_\_  
STEVEN M. CISCO

\_\_\_\_\_  
MICHAEL D. PIRAINO

\_\_\_\_\_  
MARSHALL DOUGLAS

\_\_\_\_\_  
DAVID SNETTEN

\_\_\_\_\_  
DAVID FAGAN

\_\_\_\_\_  
BRITT LIENAU

\_\_\_\_\_  
JAMES J. McNALLY

\_\_\_\_\_  
STEVE MICHAELS

**ARTICLE 10**

**COMPREHENSIVE MEDICAL EXPENSE BENEFIT**

**Section 8. Covered Expenses.**

- (t) **Durable medical equipment** which meets all of the following:
  - (i) it is for repeated use and is not a consumable or disposable item;
  - (ii) it is used primarily for a medical purpose; and
  - (iii) it is appropriate for use in the home.

The Case Manager must pre-certify the rental or purchase of equipment costing more than \$250. Failure to pre-certify will result in a benefits reduction if such a reduction is included on the Participant's Schedule of Benefits. In addition, no benefits will be paid if the equipment is not determined by the Case Manager or Administrative Manager to be Medically Necessary.

Rental of durable medical equipment is covered up to the purchase price of the equipment.

Replacement of an existing sleep apnea appliance is limited to one every five years.

- (ll) **Oral apnea appliances** recommended by a Physician and supplied by a Physician or Dentist, subject to the limitations specified on the Participant's Schedule of Benefits. Replacement of an existing appliance is limited to one every five years. No benefits will be paid for an initial or replacement appliance if the Case Manager does not pre-certify the device to be Medically Necessary.

# **APPENDIX**

**Schedule of Benefits Plan A-1  
Quarterly Employees**

**Schedule of Benefits Plan A-2  
City of Chicago – Quarterly**

**Schedule of Benefits Plan A-3  
Non-bargaining Employees**

**Schedule of Benefits Plan A-4  
Staff, Owner/Operator**

**Schedule of Benefits Plan A-5  
Municipality – Monthly**

**Schedule of Benefits Plan A-6  
Retirees**

**Schedule of Benefits Plan B-1  
Plantsmen**

**Schedule of Benefits Plan D-1  
Dental only**

**Schedule of Benefits Plan E-1  
Landscapers**

**SCHEDULE OF BENEFITS – Plan A - 1**

**QUARTERLY EMPLOYEES  
Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Disability Benefits</b>	
<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for up to 52 weeks. Eligibility is credited with 40 hours a week for the first 17 weeks
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan A - 2**

**City of Chicago - Quarterly  
Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Disability Benefits</b>	
<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for first 30 days
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$7,500 member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

## **SCHEDULE OF BENEFITS – Plan A - 3**

### **Non - Bargaining Employees Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a Physician, medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years
<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan A - 4**

Staff – Owner/Relatives

**Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only.</b> Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90%- In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Disability Benefits</b>	
<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for up to 52 weeks <b>Staff</b> – eligibility is credited with 40 hours per week for the first 4 months <b>Owner/Relative</b> – pays monthly, no credit is applied toward eligibility
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan A - 5**

**Municipality - monthly  
Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only.</b> Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Disability Benefits</b>	
<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for first 30 days
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
<b>Accidental Dismemberment Benefit</b>	
<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan A - 6**

**Retirees**

**Comprehensive Medical Expense Benefits**

<b>Annual Maximum</b> – per calendar year	\$50,000
<b>Lifetime Maximum</b>	\$750,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only.</b> Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

<b>Mental Illness and Substance Abuse</b>	
<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits
<b>Prescription Drug Program</b>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$20,000 per individual Hepatitis C maximum ends 12 months from the initial treatment - \$40,000
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	
<b>Dental Benefits</b>	
Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000
<b>Death Benefit</b>	
<b>Death Benefit</b>	\$10,000 – Local 537 members only
<b>Family Supplemental Benefit</b>	
<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500

**SCHEDULE OF BENEFITS – Plan B - 1**

**Plantsmen – monthly  
Comprehensive Medical Expense Benefits**

<b>Lifetime Maximum</b>	\$250,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$100
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$300
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	80% - In Network only
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	80% - In Network only Maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	80% - In Network only
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	80% - In Network only
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	80% - In Network only
<b>MRI and CT Scans</b>	100% - Medlink 80% - In Network Only
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	80% - In Network only
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	50% - In Network only
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	50% - In Network only calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	50% - In Network only calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	50% - In Network only calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% - In Network only lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	80% - In Network only
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% - In Network only lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 80% - In Network only
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	70% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80% - In Network only
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	80% - In Network only lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	80% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% - In Network only lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	80% - In Network only Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 80% - In Network only
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

**Prescription Drug Program**

<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days annual maximum \$7,500 per individual
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

**SCHEDULE OF BENEFITS – Plan D - 1**

**Dental Only  
Dental Expense Benefits**

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000

**SCHEDULE OF BENEFITS – Plan E - 1**

**Landscapers**

**Comprehensive Medical Expense Benefits**

<b>Lifetime Maximum</b>	\$350,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$100
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$300
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 70% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 70% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 70% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 70% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 70% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 70% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 70% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 70% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 70% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 70% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 70% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 70% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100% calendar year maximum of \$350
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% lifetime maximum of \$2,000
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 70% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 70%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	70% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	70%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network lifetime maximum \$300,000, including organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% lifetime limit \$30,000
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	70% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 70% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 70% - Out of Network
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

**Mental Illness and Substance Abuse**

<b>Mental Illness and Substance Abuse – prior authorizations from MAP provider is required</b>	
Inpatient Care	\$50 deductible 90% lifetime maximum 30 days
Outpatient Care	\$50 deductible 90% lifetime maximum 60 visits

**Prescription Drug Program**

<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 day supply Generic \$5 co-pay – 30 day supply annual maximum \$10,000 per individual
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

**Dental Benefits**

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> )	50% lifetime maximum \$750

**Death Benefit**

<b>Death Benefit</b>	\$1,000 – member
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**Family Supplemental Benefit**

<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$500
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**AMENDMENT NO. 13**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Article 10 – Comprehensive Medical Expense Benefit

Effective Date and Explanation of Revision:

Effective May 1, 2009 hearing exams by licensed audiologists will be covered under the medical plan when ordered by a medical doctor for an acute medical condition or when related to a covered surgical procedure.

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this \_\_\_th day of \_\_\_\_\_, 2010.

\_\_\_\_\_  
JAMES M. SWEENEY

\_\_\_\_\_  
JOHN E. KENNY, JR.

\_\_\_\_\_  
STEVEN M. CISCO

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MICHAEL D. PIRAINO

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MARSHALL DOUGLAS

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DAVID SNETTEN

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DAVID FAGAN

\_\_\_\_\_  
BRITT LIENAU

\_\_\_\_\_  
JAMES J. McNALLY

\_\_\_\_\_  
STEVE MICHAELS

**ARTICLE 10**

**COMPREHENSIVE MEDICAL EXPENSE BENEFIT**

**Section 8. Covered Expenses.**

- (mm) **Hearing exams** by licensed audiologists when ordered by a medical doctor for an acute medical condition or when related to a covered surgical procedure.

**AMENDMENT NO. 14**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Article 10 – Comprehensive Medical Expense Benefit

Effective Date and Explanation of Revision:

Effective January 1, 2011, cancer chemotherapy drugs used off label to treat cancer will be covered under the medical benefit, provided the Case Manager certifies that the treatment has become the standard of care.

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this 3rd day of November, 2010.

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JAMES M. SWEENEY

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JOHN E. KENNY, JR.

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STEVEN M. CISCO

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MICHAEL D. PIRAINO

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MARSHALL DOUGLAS

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DAVID SNETTEN

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DAVID FAGAN

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BRITT LIENAU

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JAMES J. McNALLY

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STEVE MICHAELS

**ARTICLE 10**

**COMPREHENSIVE MEDICAL EXPENSE BENEFIT**

**Section 8. Covered Expenses.**

- (i) **Chemotherapy drugs and supplies** administered under the direction of a Physician. Covered expenses include chemotherapy drugs used off label to treat cancer, provided the Case Manager certifies that the treatment has become the standard of care.

**AMENDMENT NO. 15**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Article 2 – Definitions

Effective Date and Explanation of Revision:

Effective January 1, 2011, children will be covered until age 26 without regard to their marital status or student status, and whether or not they are supported by the employee. However, during the period beginning January 1, 2011 and ending December 31, 2013 the Plan will exclude a child age 19 or over who is eligible for health care coverage through his or his spouse's employment.

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this 3rd day of November, 2010.

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JAMES M. SWEENEY

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JOHN E. KENNY, JR.

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STEVEN M. CISCO

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MICHAEL D. PIRAINO

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MARSHALL DOUGLAS

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DAVID SNELTEN

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DAVID FAGAN

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BRITT LIENAU

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JAMES J. McNALLY

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STEVE MICHAELS

**ARTICLE 2**  
**DEFINITIONS**

**Section 18. Eligible Dependent.**

Any or all of the following individuals:

- (a) the Eligible Employee's lawful spouse, other than a spouse separated by a decree of a court of competent jurisdiction;
- (b) those children of the Eligible Employee who have not reached their 26th birthday. During the period beginning January 1, 2011 and ending December 31, 2013 this does not include children who are eligible for health care coverage through their own or their spouse's employment.

For this purpose, "children" shall include:

- (i) natural children;
- (ii) stepchildren. Stepchildren are the natural or adopted children of an Eligible Employee's Spouse.
- (iii) legally adopted children or those for whom adoption proceedings have been started and the children are placed in the Eligible Employee's home by a licensed placement agency for the purpose of adoption.
- (iv) children for whom the Plan is required by a Qualified Medical Child Support Order (QMCSO) to consider eligible dependents. The following procedures apply to QMCSOs:
  - (A) If a copy of a proposed Medical Child Support Order as defined in ERISA Section 609(a) is filed with the Administrative Manager, the Administrative Manager shall promptly notify the Eligible Employee and each alternate recipient of the receipt of such order and the Plan's procedures for determining whether the order is a Qualified Medical Child Support Order (QMCSO), as further defined in ERISA Section 609(a).
  - (B) The Administrative Manager shall then determine whether the order is a QMCSO pursuant to the Plan's procedures, and notify the Eligible Employee and each alternate recipient of the determination.
  - (C) The Plan shall provide benefits in accordance with the applicable requirements of any QMCSO. The QMCSO shall not require any type or form of benefit or any option not otherwise provided under this Plan.

- (D) Any payment for 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 or the alternate recipient's custodial parent or legal guardian.
- (c) those children of the Eligible Employee who have reached their 26th birthday but are unmarried and incapable of self-sustaining employment by reason of mental retardation or physical handicap, provided:
  - (i) such incapacity commenced prior to the limiting age in subsection (b) above; and
  - (ii) such children are chiefly dependent upon the Eligible Employee for financial support and maintenance; and
  - (iii) the Eligible Employee submits satisfactory proof of such incapacity within 31 days after the upper age limit is reached. The Trustees may require, at reasonable intervals following the date the dependent reaches the age limit, subsequent proof of continuing incapacity and dependency. The Trustees reserve the right to have such dependent examined by a Physician of their choice to determine the existence of such incapacity.

“Mental retardation” means significantly subaverage, general intellectual functioning which exists concurrently with impairment in adaptive behavior.

**AMENDMENT NO. 16**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

Article 10 – Comprehensive Medical Expense Benefit

Effective Date and Explanation of Revision:

Effective January 1, 2011, the pre-existing condition limitation will not apply to children under age 19.

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this 3rd day of November, 2010.

\_\_\_\_\_  
JAMES M. SWEENEY

\_\_\_\_\_  
JOHN E. KENNY, JR.

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STEVEN M. CISCO

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MICHAEL D. PIRAINO

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MARSHALL DOUGLAS

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DAVID SNELTEN

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DAVID FAGAN

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BRITT LIENAU

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JAMES J. McNALLY

\_\_\_\_\_  
STEVE MICHAELS

## ARTICLE 10

### COMPREHENSIVE MEDICAL EXPENSE BENEFIT

#### Section 7. Pre-Existing Conditions.

- (a) Payment for a Participant's Covered Expenses, including covered prescription drugs, incurred for a Pre-Existing Condition will be made up to a maximum of \$15,000, during the twelve-month period that begins with the individual's Enrollment Date, provided, however, that this twelve-month period shall be reduced by the number of days of prior creditable coverage the affected individual has as of his Enrollment Date.
- (b) "Creditable coverage," as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), generally means health care coverage provided by a group, individual or public health plan. The affected individual is required to demonstrate his prior creditable coverage by presenting a written certification of health coverage as provided to him by the plan providing the coverage, or if the individual did not receive a certificate, the individual has a right to demonstrate creditable coverage through the presentation of documentation or other means. Days of creditable coverage that occur before a Break in Coverage will not be used to reduce the length of an individual's Pre-Existing Condition limitation period.
- (c) The Pre-Existing Condition limitation shall not apply to Pregnancy. In addition, a Pre-existing Condition limitation period shall not be applied to a child under age 19.

**AMENDMENT NO. 17**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

Amendment applicable to:

- Article 10 – Comprehensive Medical Expense Benefit
- Appendix – Schedules A-1, A-2, A-3, A-4, A-5, A-6, B-1 and E-1

Effective Date and Explanation of Revision:

Effective January 1, 2011:

- An aggregate annual dollar limit in the amount of \$820,000 will apply to all Comprehensive Benefits and prescription drug benefits in 2011. This dollar limit will increase to \$1,250,000 in 2012 and to \$2,000,000 in 2013. (For Plan B and Plan E, the 2011 limit will be \$750,000.) The new annual dollar limits replace the current aggregate lifetime and annual dollar limits on medical and prescription drug benefits.
- The Plan's dollar limits on the following specific benefits will also be removed: preventive care for member and spouse (\$350 per year), well-baby care for first two years (\$2,000), transplants (\$300,000), cochlear implants for participants age 19 or over (\$30,000), Hepatitis C drugs (\$40,000 in a 12-month period). Benefits paid for transplants will apply to the aggregate annual dollar limit.

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this 3rd day of November, 2010.

\_\_\_\_\_  
JAMES M. SWEENEY

\_\_\_\_\_  
JOHN E. KENNY, JR.

\_\_\_\_\_  
STEVEN M. CISCO

\_\_\_\_\_  
MICHAEL D. PIRAINO

\_\_\_\_\_  
MARSHALL DOUGLAS

\_\_\_\_\_  
DAVID SNETTEN

\_\_\_\_\_  
DAVID FAGAN

\_\_\_\_\_  
BRITT LIENAU

\_\_\_\_\_  
JAMES J. McNALLY

\_\_\_\_\_  
STEVE MICHAELS

**ARTICLE 17**

**COMPREHENSIVE MEDICAL EXPENSE BENEFIT**

**Section 6. Maximum Benefit.**

The overall Maximum Benefit payable under this Article for all Covered Expenses incurred by a Participant due to all Injuries or Illnesses in a Calendar Year is specified on the Participant's Schedule of Benefits.

**Section 8. Covered Expenses.**

- (o) **Newborn and well child** outpatient and office visits and routine childhood immunizations for a Dependent child from birth through age 24 months.

**ARTICLE 12**

**TRANSPLANT BENEFITS**

**Section 5. Benefits Payable.**

- (b) The following aggregate limits apply:
  - (i) a \$25,000 limit on organ or tissue procurement;
  - (ii) a \$10,000 limit for transportation and lodging; and
  - (iii) a \$10,000 limit for private duty nursing care.
- (c) Benefits paid by the Plan for a covered transplant procedure also apply to the Participant's Maximum Benefit under the Comprehensive Medical Expense Benefit.

# **APPENDIX**

**Schedule of Benefits Plan A-1  
Quarterly Employees**

**Schedule of Benefits Plan A-2  
City of Chicago – Quarterly**

**Schedule of Benefits Plan A-3  
Non-bargaining Employees**

**Schedule of Benefits Plan A-4  
Staff, Owner/Operator**

**Schedule of Benefits Plan A-5  
Municipality – Monthly**

**Schedule of Benefits Plan A-6  
Retirees**

**Schedule of Benefits Plan B-1  
Plantsmen**

**Schedule of Benefits Plan E-1  
Landscapers**

**SCHEDULE OF BENEFITS – Plan A - 1**

**QUARTERLY EMPLOYEES  
Comprehensive Medical Expense Benefits**

<b>Calendar Year Maximum</b> – for all medical and prescription drug benefits	2011 – \$820,000 2012 – \$1,250,000 2013 – \$2,000,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000
<b>Orthoptic Training</b> – for dependent children up to age	50%

10 <b>only</b> . Training needs to be prescribed by a covered provider.	lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100%
<b>Well Baby Care</b> – includes routine hospital visits, out-patient visits and immunizations, age limitation of 0 to 24 months	100%
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70%
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

**Mental Illness and Substance Abuse**

<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits

**Prescription Drug Program**

<i>Prescription drug benefits apply to the Comprehensive Medical Expense Benefit Calendar Year Maximum.</i>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days Hepatitis C drugs limited to one 12-month treatment
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

**Dental Benefits**

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000

**Disability Benefits**

<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for up to 52 weeks. Eligibility is credited with 40 hours a week for the first 17 weeks
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**Death Benefit**

<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
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**Accidental Dismemberment Benefit**

<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
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**Family Supplemental Benefit**

<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500
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**SCHEDULE OF BENEFITS – Plan A - 2**

**City of Chicago - Quarterly  
Comprehensive Medical Expense Benefits**

<b>Calendar Year Maximum</b> – for all medical and prescription drug benefits	2011 – \$820,000 2012 – \$1,250,000 2013 – \$2,000,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only.</b> Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100%
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100%
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70%
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

**Mental Illness and Substance Abuse**

<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits

**Prescription Drug Program**

<i>Prescription drug benefits apply to the Comprehensive Medical Expense Benefit Calendar Year Maximum.</i>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days Hepatitis C drugs limited to one 12-month treatment
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

**Dental Benefits**

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000

**Disability Benefits**

<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for first 30 days
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**Death Benefit**

<b>Death Benefit</b>	\$7,500 member \$2,000 dependent
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**Accidental Dismemberment Benefit**

<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
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**Family Supplemental Benefit**

<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500
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## **SCHEDULE OF BENEFITS – Plan A - 3**

### **Non - Bargaining Employees Comprehensive Medical Expense Benefits**

<b>Calendar Year Maximum</b> – for all medical and prescription drug benefits	2011 – \$820,000 2012 – \$1,250,000 2013 – \$2,000,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100%
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100%
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70%
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a Physician, medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years
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**Mental Illness and Substance Abuse**

<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits

**Prescription Drug Program**

<i>Prescription drug benefits apply to the Comprehensive Medical Expense Benefit Calendar Year Maximum.</i>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days Hepatitis C drugs limited to one 12-month treatment
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

**Dental Benefits**

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000

**Death Benefit**

<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
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**Accidental Dismemberment Benefit**

<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
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**Family Supplemental Benefit**

<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500
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**SCHEDULE OF BENEFITS – Plan A - 4**

Staff – Owner/Relatives

**Comprehensive Medical Expense Benefits**

<b>Calendar Year Maximum</b> – for all medical and prescription drug benefits	2011 – \$820,000 2012 – \$1,250,000 2013 – \$2,000,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only.</b> Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100%
<b>Well Baby Care</b> – includes routine hospital visits, out-patient visits and immunizations, age limitation of 0 to 24 months	100%
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70%
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

**Mental Illness and Substance Abuse**

<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits

**Prescription Drug Program**

<i>Prescription drug benefits apply to the Comprehensive Medical Expense Benefit Calendar Year Maximum.</i>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days Hepatitis C drugs limited to one 12-month treatment
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

**Dental Benefits**

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000

**Disability Benefits**

<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for up to 52 weeks <b>Staff</b> – eligibility is credited with 40 hours per week for the first 4 months <b>Owner/Relative</b> – pays monthly, no credit is applied toward eligibility
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**Death Benefit**

<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
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**Accidental Dismemberment Benefit**

<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
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**Family Supplemental Benefit**

<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500
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**SCHEDULE OF BENEFITS – Plan A - 5**

**Municipality - monthly  
Comprehensive Medical Expense Benefits**

<b>Calendar Year Maximum</b> – for all medical and prescription drug benefits	2011 – \$820,000 2012 – \$1,250,000 2013 – \$2,000,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100%
<b>Well Baby Care</b> – includes routine hospital visits, out-patient visits and immunizations, age limitation of 0 to 24 months	100%
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70%
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

### Mental Illness and Substance Abuse

<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits

### Prescription Drug Program

<i>Prescription drug benefits apply to the Comprehensive Medical Expense Benefit Calendar Year Maximum.</i>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days Hepatitis C drugs limited to one 12-month treatment
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

### Dental Benefits

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000

### Disability Benefits

<b>Disability Benefit</b> – must be an eligible member under Health and Welfare	\$250 per week for first 30 days
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### Death Benefit

<b>Death Benefit</b>	\$30,000 – member \$2,000 dependent
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### Accidental Dismemberment Benefit

<b>Accidental Dismemberment Benefit</b>	\$1,000 or \$5,000 based on type of loss. Limited to \$10,000 for any one accident
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### Family Supplemental Benefit

<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500
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**SCHEDULE OF BENEFITS – Plan A - 6**

**Retirees**

**Comprehensive Medical Expense Benefits**

<b>Calendar Year Maximum</b> – for all medical and prescription drug benefits	2011 – \$820,000 2012 – \$1,250,000 2013 – \$2,000,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$300
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$700
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 80% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 80% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 80% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 80% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 80% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 80% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 80% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 80% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 80% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only.</b> Requires approval by Case Management.	90% - In Network 80% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 80% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100%
<b>Well Baby Care</b> – includes routine hospital visits, out-patient visits and immunizations, age limitation of 0 to 24 months	100%
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 80% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	80% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70%
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 80% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 80% - Out of Network
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

**Mental Illness and Substance Abuse**

<b>Mental Illness and Substance Abuse</b> – prior authorizations from MAP provider is required	
Inpatient Care	90% lifetime maximum 30 days
Outpatient Care	90% lifetime maximum 60 visits

**Prescription Drug Program**

<i>Prescription drug benefits apply to the Comprehensive Medical Expense Benefit Calendar Year Maximum.</i>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days Hepatitis C drugs limited to one 12-month treatment
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<b>Nursing Home</b>	50% - prescription drugs
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

**Dental Benefits**

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> ), for treatment that started on or after 1/1/09	50% lifetime maximum \$2,000

**Death Benefit**

<b>Death Benefit</b>	\$10,000 – Local 537 members only
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**Family Supplemental Benefit**

<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$1,500
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**SCHEDULE OF BENEFITS – Plan B - 1**

**Plantsmen – monthly**

**Comprehensive Medical Expense Benefits**

<b>Calendar Year Maximum</b> – for all medical and prescription drug benefits	2011 – \$750,000 2012 – \$1,250,000 2013 – \$2,000,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$100
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$300
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	80% - In Network only
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	80% - In Network only Maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	80% - In Network only
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	80% - In Network only
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	80% - In Network only
<b>MRI and CT Scans</b>	100% - Medlink 80% - In Network Only
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	80% - In Network only
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	50% - In Network only
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	50% - In Network only calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	50% - In Network only calendar year maximum \$500
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	50% - In Network only calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% - In Network only lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	80% - In Network only
<b>Well Baby Care</b> – includes routine hospital visits, outpatient visits and immunizations, age limitation of 0 to 24 months	100% - In Network only
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 80% - In Network only
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 80%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	70% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	80% - In Network only
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	80% - In Network only organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	80% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70% - In Network only
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	80% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	80% - In Network only Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 80% - In Network only
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

**Prescription Drug Program**

*Prescription drug benefits apply to the Comprehensive Medical Expense Benefit Calendar Year Maximum.*

<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days Hepatitis C drugs limited to one 12-month treatment
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*When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.*

**SCHEDULE OF BENEFITS – Plan E - 1**

**Landscapers**

**Comprehensive Medical Expense Benefits**

<b>Calendar Year Maximum</b> – for all medical and prescription drug benefits	2011 – \$750,000 2012 – \$1,250,000    2013 – \$2,000,000
<b>Individual Deductible</b> – (per person, per calendar year. All benefits are subject to the deductible unless otherwise noted) Three month carryover	\$100
<b>Family Deductible</b> - (per calendar year) Three month carryover does not apply.	\$300
<b>Out of pocket expense limitation</b> – The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, <b>including the deductible.</b>	\$2,500 per individual \$6,000 per family
<b>PPO Network</b>	BlueCross BlueShield – Hospital and Physicians Medlink – MRI and CT Scans Compsych – MAP, Mental and Nervous and Substance Abuse
<b>Inpatient Hospital Services</b> – Room allowances based on the hospital’s most common semi-private room rate. Pre-admission testing, 14 days prior to admission	90% - In Network 70% - Out of Network
<b>Skilled Nursing Facility</b> - recommended by a Physician and confinement begins within 30 days of a hospital confinement	90% - In Network 70% - Out of Network maximum per disability – 45 days
<b>Home Health Care</b> – ordered by a physician. Approval by Case Management required	90% - In Network 70% - Out of Network
<b>Outpatient Hospital Services</b> – including Licensed Surgery Centers	90% - In Network 70% - Out of Network
<b>Diagnostic X-rays/Lab</b> – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	90% - In Network 70% - Out of Network
<b>MRI and CT Scans</b>	100% - Medlink 90% - In Network 70% - Out of Network
<b>Outpatient Physical and Occupational Therapy</b> – requires approval by Case Management. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	90% - In Network 70% - Out of Network
<b>Outpatient Restorative Speech Therapy- (children and adults)</b> requires approval by Case Management. Must be performed by a Licensed Speech Therapist.	90% - In Network 70% - Out of Network
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 2 through age 5. Requires approval by Case Management	90% - In Network 70% - Out of Network calendar year maximum \$2,000
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children</b> – dependent children age 6 through age 18. Requires approval by Case Management	90% - In Network 70% - Out of Network calendar year maximum \$300
<b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children</b> – dependent children through age 18 <b>only</b> . Requires approval by Case Management.	90% - In Network 70% - Out of Network calendar year maximum \$5,000

<b>Orthoptic Training</b> – for dependent children up to age 10 <b>only</b> . Training needs to be prescribed by a covered provider.	50% lifetime maximum 40 visits
<b>Physician's Medical/Surgical Care</b> - Office visits, hospital visits, surgery, assistant surgeon, etc	90% - In Network 70% - Out of Network
<b>Preventative Care</b> -routine physical exams. Benefit for member and spouse <b>only</b> .	100%
<b>Well Baby Care</b> – includes routine hospital visits, out-patient visits and immunizations, age limitation of 0 to 24 months	100%
<b>Chiropractic Services</b> – eligible for members and dependents over age 5. Medically necessary x-rays are covered	maximum of 24 spinal manipulations per calendar year up to \$60 per visit 90% - In Network 70% - Out of Network
<b>Durable Medical Equipment</b> – rental paid up to purchase price of the equipment	No deductible 70%, if pre-approved by a case manager, 50%, not pre-approved Electric wheelchair limited to \$15,000
<b>Foot Orthotics</b> – custom fitted foot orthotics prescribed by a Physician	70% annual maximum \$300 lifetime maximum \$1,500
<b>Prosthetic devices</b> – artificial devices to restore a normal body function. Case Management approval is required. An electronic or microprocessor controlled artificial limb is limited to the cost of a conventional mechanical artificial limb that would meet the patient's basic needs.	70%
<b>Transplants</b> - Case Management approval is required. Available to all active and non-Medicare members. Medicare eligible members must use Medicare approved providers. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	90% - In Network organ procurement maximum \$25,000 per transplant transportation and lodging maximum \$10,000 private duty nursing maximum \$10,000
<b>Temporomandibular Joint Disease (TMJ)</b> – precertification is required	No deductible 50% lifetime maximum \$2,500
<b>Cochlear Implants</b> – for dependent children age 1 through 18. Requires approval by Case Management	90% - In Network only
<b>Cochlear Implants</b> – age 19 and older. Requires approval by Case Management.	70%
<b>Cancer drugs</b> – drugs used to treat cancer are subject to the annual deductible, annual and lifetime maximum	70% of the prescription charge
<b>Medical Transportation</b> – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility	90% - In Network 70% - Out of Network Inter-health-care-facility transfer maximum \$5,000
<b>Acupuncture</b> – services performed by a licensed acupuncturist (Physician referral required) or Physician	maximum of 12 treatments per calendar year up to \$125 allowable per visit 90% - In Network 70% - Out of Network
<b>Sleep Apnea Appliances</b> – when ordered by a Physician and provided by a medical equipment supplier or Dentist	90% - In Network 80% - Out of Network maximum every five years \$3,000 all appliances replacement of existing appliance covered every five years

**Mental Illness and Substance Abuse**

<b>Mental Illness and Substance Abuse – prior authorizations from MAP provider is required</b>	
Inpatient Care	\$50 deductible 90% lifetime maximum 30 days
Outpatient Care	\$50 deductible 90% lifetime maximum 60 visits

**Prescription Drug Program**

<i>Prescription drug benefits apply to the Comprehensive Medical Expense Benefit Calendar Year Maximum.</i>	
<b>Midwest Benefit Pharmacy</b> All maintenance drugs must be purchased at the Midwest Benefit Pharmacy. No Coordination of Benefits applies	Brand \$10 co-pay – 30 days Generic \$5 co-pay – 30 days Hepatitis C drugs limited to one 12-month treatment
<b>Pharmacy Benefit Manager (local pharmacy) – In Network Pharmacy Only</b>	80% for emergency medication only from an in-network pharmacy. A maximum of 15 days supply will be dispensed
<i>When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If a participant requests a Brand Name Drug, or if the prescribing Physician indicates "no substitutions", when a Generic equivalent is available, the Participant will be required to pay the Brand Name Drug Co-Pay plus the difference in cost between the Brand Name Drug and its Generic equivalent.</i>	

**Dental Benefits**

Deductible	\$0
Calendar Year Maximum	\$1,000
<b>PPO Network</b>	DentalGuard Preferred Select Network
Preventative	100%
Basic and restorative	70%
Orthodontia (dependent children through age 18 <b>only</b> )	50% lifetime maximum \$750

**Death Benefit**

<b>Death Benefit</b>	\$1,000 – member
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**Family Supplemental Benefit**

<b>Family Supplemental Benefit</b> This benefit can be used for non-covered expenses. Items such as hearing aids, glasses, etc. Non-covered drugs except for prescriptions which could have been purchased under the Prescription Drug Program. Reimbursement for plan maximums and items considered at 50% except for durable medical equipment is eligible. This benefit cannot be used to reimburse the deductible, co-pay or amount over the reasonable and customary amount.	maximum per family, per calendar year - \$500
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**AMENDMENT NO. 18**

**TO THE HEALTH AND WELFARE PLAN OF THE  
MIDWEST OPERATING ENGINEERS WELFARE FUND  
AS RESTATED AND EFFECTIVE JANUARY 1, 2008**

The Board of Trustees hereby amends the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, as restated and effective January 1, 2008, as outlined below, and the pages containing the amended provisions attached hereto are made a part of the Plan.

At the Board of Trustees Meeting held on October 27, 2009, it was agreed that the policy of the Fund regarding subrogation shall be that there will be no waiver of the rights of the Fund in any subrogation matter regarding any claim by the Fund as the result of third-party recoveries by a Plan participant. Therefore, the Plan should be amended to clarify the Welfare Fund's two-year-no-reimbursement rule. The language was also modified to clarify the starting date of the two-year period as follows:

**ARTICLE 16 – SUBROGATION**

Section 1 (Paragraph 5) shall be amended to read as follows and shall replace the prior paragraph:

**The Welfare Fund will not reimburse any expense subject to subrogation related to a tortious act or conduct of a third party for a period of two years from the date upon which a Settlement Agreement related to said tortious act or conduct is fully executed.**

Section 2 (Paragraph 5) shall be amended to read as follows and shall replace the prior paragraph:

**The Welfare Fund will not reimburse any expense subject to subrogation related to a Work-Related Illness or Injury for a period of two years from the date upon which a Settlement Agreement related to said Work-Related Illness or Injury is fully executed.**

IN WITNESS WHEREOF, the undersigned, being all of the Trustees of the Health and Welfare Plan of the Midwest Operating Engineers Welfare Fund, have hereunto set their hands this \_\_\_th day of \_\_\_\_\_, 2010.

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JAMES M. SWEENEY, Chairman

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JOHN E. KENNY, JR., Secretary

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STEVEN M. CISCO

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DAVID SNELTEN

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DAVID A. FAGAN

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MICHAEL D. PIRAINO

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MARSHALL DOUGLAS

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STEVE MICHAELS

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JAMES J. MCNALLY

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BRITT LIENAU