October 2005

Dear Participant:

As the Trustees of your Plan, we are pleased to offer coverage to help you meet your health care needs. With the skyrocketing cost of health care, we know how important these comprehensive benefits can be to you and your family. While many Funds have been reducing benefits, we are proud that our Plan has made several benefit improvements over the last couple of years. In addition to some Plan improvements, we've also made some changes to clarify Plan provisions as well as to comply with legislative requirements. We have tried to keep you up to date on all Plan changes as they occur by including information in the newsletter. At this time, we would like to take this opportunity to describe all recent changes, including some changes effective January 1, 2006.

Plan Improvements And Changes

- Added Plan C coverage for members eligible to make self-payments for active coverage.
- Enhanced eligibility provisions for dependent children that are full-time students.
- Added coverage for surviving spouses of retirees.
- Enhanced eligibility provisions for dependents of retirees.
- Improved medical benefits by:
  - Increasing adult preventive care calendar year maximum.
  - Changing chiropractic treatment provisions.
  - Enhancing MRI and CT scans coverage.
  - Increasing wheelchair maximum.
- Prescription drug benefits changed by:
  - Improving benefits by providing a separate higher maximum for initial treatment of Hepatitis C.
  - Adding a generic substitution requirement to help you get the most of your prescription drug benefits.
  - Modifying the retail prescription drug copayments.
- Improved dental benefits by increasing calendar year maximum.

Plan Clarifications And Legislative Compliance Changes

- Purpose of the Plan restated.
- Definition of dependent updated to comply with recent legislative changes.
- Covered dependents may be eligible to continue benefits during military leave.
- Retiree eligibility extended to include municipal and government employees.
- Special enrollment rights for eligible dependents of retirees.
- Retiree self-payments due monthly.
- Clarified over-the-counter medications coverage.
- Eliminated suicide or self-inflicted injuries exclusion.
- Clarified exclusion for transsexual procedures.
- Implemented new privacy procedures for use and disclosure of private health care information, per federal guidelines.
- Adopted new claims and appeals procedures, per federal guidelines.

These changes are described in more detail in the following information; please read this information to see how these changes affect you and your dependents. Also included with this letter is a revised *Schedule Of Benefits* that provides an overview of your benefits under the Plan as of January 1, 2006. Please keep these materials in the back pocket of your Summary Plan Description.

We continually monitor the Plan to ensure that we provide the best benefits possible given the available resources. If you have questions about this information or your benefits in general, please contact the Fund Office.

Sincerely,
Board Of Trustees

This announcement serves as a Summary of Material Modifications and contains only highlights of certain features of the Midwest Operating Engineers Health & Welfare Plan. Full details are contained in the Plan Documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the Plan Document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

Plan Improvements And Changes

Plan C Coverage Available For Active Members—Effective July 1, 2004

Plan C, an alternative level of coverage, was established for members eligible to make active self-payments to continue coverage (known as Plan A coverage). In exchange for lower self-payment contributions, Plan C provides a lower level of coverage than the active Plan. Plan C is available if you are an active member who would otherwise lose eligibility for coverage because the required number of hours were not contributed on your behalf or if you are disabled.

If your eligibility would otherwise end under one of these situations, you will be given the option to make self-payments, for up to four consecutive contribution quarters, for Plan A or Plan C coverage. You will be notified of the current cost of coverage for both options when you become eligible to make self-payments. If you elect Plan C coverage, you can only reinstate your active Plan A coverage by satisfying the Plan's initial eligibility requirements.

Plan C coverage is highlighted in the attached *Plan C Schedule Of Benefits*. Please note that if you are covered under Plan A and then move to Plan C coverage, the deductible and any maximums apply to both. For example, if you have already satisfied the deductible under Plan A when you move to Plan C, you will not need to meet any additional deductible amounts.

Enhanced Eligibility For Student Coverage – Effective January 1, 2000

A dependent child whose eligibility ends because he or she is no longer a full-time student after attaining age 19 but before reaching age 23, who subsequently re-enrolls as a full-time student, may again become eligible for Plan benefits. You must make a one-time election to make self-payments to maintain eligibility for the period of time your child was not a full-time student. The self-payment amount will be equal to the COBRA rate times the number of months your child was not eligible, up to a maximum of nine months. You or your dependent must notify the Fund Office, in writing, of your election and you must make full payment within 30 days.

Your dependent's eligibility ends upon the earliest of the:

- Date the dependent no longer meets the Plan's definition of dependent;
- Last day of the benefit quarter, if eligibility ends due to a COBRA qualifying event;
- Last day of the benefit quarter (or month, as applicable) during which your dependent child ceases to be a full-time student (However, a dependent child who is a full-time student in both the spring semester and subsequent fall semester will remain eligible between semesters); or
- Date your coverage ends.

Retiree Surviving Spouses Coverage Available – Effective January 1, 2002

While the Plan's Retiree Benefits are not new nor is coverage for surviving spouses of active members, retiree coverage has now been expanded to include coverage for retirees' surviving spouses. In the event of your death while covered under the Plan's Retiree Benefits, your surviving spouse may elect to continue coverage under the Plan's Retiree Benefits. To be eligible for this survivor coverage, your surviving spouse must have been eligible for Retiree Benefits before your death and must make the required self-payments on a timely basis.

Enhanced Eligibility For Coverage For Dependents Of Retirees – Effective January 1, 2000

The Plan now provides special enrollment rights to eligible dependents of retirees who initially decline Retiree Benefits because the dependent was covered under another group health plan or had health insurance coverage at

the time the retiree initially became eligible for Retiree Benefits. If the dependent subsequently loses that other coverage, for reasons other than fraud or failure to make the required payments, the retiree may enroll the dependent for coverage under the Plan's Retiree Benefits.

Self-payments are required and must be made on a timely basis. You must apply for coverage for your 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 and coverage for that dependent will begin on the first day of the month after the application and self-payment are received at the Fund Office.

Improved Medical Benefits

The Plan made the following medical benefit improvements.

- ***Increased Calendar Year Adult Preventive Care Maximum – Effective January 1, 2002.*** The Plan provides preventive care benefits for employees, retirees, and their eligible spouse. The calendar year preventive care maximum increased from $250 to $350. Each calendar year, the Plan pays up to this maximum for covered preventive care services for each individual. For a listing of covered preventive care services, see your Summary Plan Description.
- ***New Chiropractic Treatment Provisions – Effective January 1, 2003.*** The chiropractic treatment maximum is 24 spinal manipulations per calendar year. The Plan allows up to the first $60 of covered expenses per spinal manipulation. The percentage the Plan pays depends on whether or not you use PPO-providers. Chiropractic care benefits are payable only for spinal manipulations provided to covered individuals five years of age and older.
- ***Increased Coverage For MRI And CT Scans – Effective January 1, 2004.*** MRIs and CT scans continue to be covered medical expenses. However, these expenses are covered at 100%, after your satisfy your deductible, when services are received through Medlink.
- ***New Wheelchair Maximum – Effective January 1, 2004.*** The lifetime maximum for electronic or mechanized wheelchair expenses is $15,000.

Prescription Drug Benefit Changes

- ***Hepatitis C Treatment Benefits – Effective January 1, 2004***. The Plan pays up to $40,000 for the initial course of treatment for Hepatitis C during a 12-month period. This includes the following medications relating to the treatment of Hepatitis C:
  - Peg-intron;
  - Rebetron; and
  - Rebetol.
- ***New Co-Payment Amounts –Effective January 1, 2006.*** When you have a prescription filled at the Midwest Benefit Pharmacy, for each 30-day supply, you will pay:
  - $5 for a generic medication; or
  - $10 for a brand name medication.
- ***Brand Name Medications – Effective January 1, 2006.*** When available, generic medications will be substituted for brand name medications. If you request a brand name medication when a generic is available, you will be required to pay the brand name drug co-payment plus the difference in cost between the brand name and generic medication.

Increased Dental Calendar Year Maximum – Effective January 1, 2002

The dental benefit maximum increased from $800 to $1,000. Each calendar year, the Plan pays up to this maximum for covered dental services for each individual.

Plan Clarifications And Legislative Compliance Changes

Plan Purpose

The Fund provides comprehensive health care coverage intended to help you and your eligible dependents stay healthy and provides financial protection against catastrophic health care costs. Although benefits include reimbursement for a broad array of services and supplies given for medically necessary and appropriate care, not all types of treatment are covered.

Consistent with the Trustees, or their designees, obligation to maintain, within the resources available, a sound and economical program providing reasonable benefits for you and your dependents, the Trustees have the right, in their sole discretion, to:

- Establish, amend, or terminate the amount, eligibility requirements, or conditions with respect to any benefit;
- Alter the method of paying any benefit;
- Amend any provision of the Plan; and
- Interpret the Plan.

New Definition Of Dependent – Effective January 1, 2005

The Plan's dependent definition was updated to parallel the dependent definition under the Working Families Tax Relief Act of 2004. This was done to ensure that your dependents benefits are not considered taxable income. The Plan's dependent definition includes your:

- Lawful spouse, other than a spouse separated by a Decree of a Court of Competent Jurisdiction; and
- Children who are unmarried and primarily dependent on you for support and maintenance and have not reached their 19th birthday. Children must reside with you for more than one-half of the calendar year. An exception applies to children whose parents are divorced or separated,

Children include:

- Your natural children;
- Your spouse's natural or adopted (or placed for adoption) children (i.e., stepchildren); and
- Your legally adopted children (including children for whom adoption proceedings have been started that are placed in your home by a licensed placement agency for the purpose of adoption).

Eligible children who have reached their 19th birthday but who totally and permanently disabled (as defined in Internal Revenue Code Section 22 (e)(3)) at any time during the calendar year are covered, provided:

- The total and permanent disability began before the limiting age;
- You provide over one-half of the child's support for the calendar year;
- The child resides with you for over one-half of the calendar year (an exception applies to children whose parents are divorced or separated, as set forth in Internal Revenue Code 152(e)); and

- You provide satisfactory proof of such total and permanent disability 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 total and permanent disability. The Trustees reserve the right to have the dependent examined by a Physician of their choice to determine the existence of the disability.

Full-time students, who were eligible dependents at the time they reach their 19th birthday and have not reached their 23rd birthday are also covered. The student must reside with you for more than one-half of the calendar year (an exception applies to children whose parents are divorced or separated, as set forth in Internal Revenue Code section 152(e)) and you must provide more than one-half of the student's support for the calendar year. 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.

Covered Dependents Eligible To Continue Benefits During Military Leave – Effective January 1, 2003

If your eligible dependent is called into duty in the uniformed services, he or she may be able to continue medical benefits under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA). If he or she enters military service (active duty or inactive duty training) for up to 31 days, health care coverage will continue if the required coverage payment is made. If military service is for more than 31 days, coverage can continue by making the required coverage payment for up to 18 months (24 months effective as of December 10, 2004) under USERRA. You or your dependent needs to notify the Fund Office, in writing, when he or she enters the military. For more information about coverage payments under USERRA, contact the Fund Office.

You, the member, must be eligible for benefits for your dependent to be eligible for any coverage while on, or returning from, military leave.

Following discharge from the uniformed services, your dependent's coverage may be reinstated if he or she meets the definition of a dependent under the Plan. See your Summary Plan Description for the definition of a dependent.

Retiree Benefits Available For Municipal And Government Employees – Effective February 1, 2002

Eligibility for the Plan's Retiree Benefits was extended to municipality or other government agency employees covered under a collective bargaining agreement with the Union. To be eligible for coverage under the Plan's Retiree Benefits, you must:

- Be at least age 55 and retire from active employment;
- Be receiving a normal retirement, early retirement, or total and permanent disability retirement pension under the Illinois Municipal Retirement Fund;
- Have at least 10 years of service under the Illinois Municipal Retirement Fund;
- Have been covered under the active Plan for at least 10 years unless:
  - You are a member of a bargaining unit represented by the Union on the effective date of the initial collective bargaining agreement between the municipality or other government agency;
  - The municipality or government agency on the effective date of the initial collective bargaining agreement provides retiree health benefits that are partially or fully paid by you; and

If you meet the requirements, you will be considered to have been covered by this Plan as an active employee for 10 years, even if you have been covered under this Plan for less than 10 years.

Special Enrollment Rights For Dependents Of Retirees

When you are eligible for retiree coverage, you must elect coverage for your dependents at the time you retire. Generally, if you do not, you will not be able to add dependent coverage at a later date unless you acquire new dependents, such as through marriage or birth. The Plan was clarified, per federal regulations, to include that you may also add an eligible dependent that you acquire through adoption and placement for adoption.

If you elect to cover only yourself when you first retire and later acquire a new dependent as the result of marriage, birth, adoption, or placement for adoption, you may add your new eligible dependent within six months of acquiring the dependent. Coverage begins on the first day of the month after your application and payment are received. Payment must be made within 30 days after receipt of your application.

The Plan was further clarified, per federal law, that you may also add an eligible dependent if you declined coverage for that dependent when you first retired because the dependent had other health insurance coverage that the dependent subsequently loses. In this instance, you must add the dependent within 30 days after the other coverage ends. However, your dependent is only eligible if the other coverage ends for reasons other than fraud or failure to make the required payment for coverage, including COBRA or any other continuation coverage available under a group plan or insurance contract. Your dependent's coverage will begin on the first day of the month after your application and payment are received. Payment must be made within 30 days after receipt of your application.

Retiree Self-Payments Due Monthly—Effective January 1, 2002

Once you retire, if you are eligible for retiree coverage, you must make self-payments, at the required amount. Effective January 1, 2002, the Plan required that self-payments for retiree coverage be made on a monthly, rather than quarterly, basis.

Payments can either be automatically deducted from the retiree's pension check (which is done as of the first day of the month) or the retiree can send in a check with a self-payment coupon. If the retiree uses the coupons, the self-payment is due on the 15th of the month before the month of coverage.

Over-The-Counter Medications Clarification

While over-the-counter medications have never been covered under the Plan, the Plan Document was amended to further clarify that over-the-counter medications that do not require a prescription are not covered under the Family Supplemental Benefit and are not considered an eligible expense under the Plan.

Eliminated Suicide Or Self-Inflicted Injuries Exclusion – Effective January 1, 2004

The exclusion for expenses that result from a suicide attempt, or self-inflicted injury or illness no longer applies.

Adding A Transsexual Procedure Exclusion

While medical, surgical, or prescription drug treatment related to transsexual (sex change) preparation, procedures, or any complications resulting from these procedures are not covered under the Plan, the Plan Document was amended to clarify this exclusion.

Privacy Protection – Effective April 14, 2003

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of private health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice, which was distributed last year or when you became eligible under the Plan. For a copy of the Notice, please contact the Administrative Manager. If you have questions about the privacy of your health information or wish to file a complaint about a privacy issue, please contact the Administrative Manager.

Requests for the Privacy Notice should be addressed to HIPAA Privacy Officer, 6150 Joliet Rd., Countryside, Illinois 60525.

This statement does not represent the Plan's Privacy Notice.

New Claims And Appeals Procedures – Effective January 1, 2002

The claims and appeals procedures apply to health benefit claims received on or after January 1, 2003, and disability and all other benefits claims received on or after January 1, 2002.

Definitions

These definitions apply to claims and appeals procedures:

- **Days** – Calendar days, not business days.
- **Discretionary Authority of Administrative Manager and Designees** – The Trustees, Review Panel, and other designated individuals have authority to interpret the terms of the Health & Welfare Fund Trust Agreement, Plan, Summary Plan Description, Plan Documents, and the procedures of the Fund and Plan to determine Plan benefits. Benefits will be paid only if the Administrative Manager (subject to appeal) and the Trustees (or Review Panel) decide in their discretion that the applicant is entitled to them. Interpretation or determination made under discretionary authority will be given full force and effect, unless it is shown that the interpretation or determination was arbitrary and capricious.
- **Claim** – A request for a benefit from the Plan made by a participant ("claimant" or "patient") or an individual's authorized representative.
- **Authorized Representative** – The person with authority to act on the participant's behalf to file a claim in accordance with the Plan's claims procedures. Unless you elect otherwise, the Plan will consider you to be the authorized representative for your dependents, and your spouse will be considered an authorized representative for you and any dependent children. The following may be recognized as the claimant's authorized representative:
  - Health care provider;
  - Dependent child age 18 or older;
  - Parents or adult siblings;
  - Grandparent;
  - Court ordered representative, such as an individual with power of attorney for health care purposes or legal guardian or conservator; or
  - Other adult.

The Plan requires a written statement from you or you spouse that one of the above individuals has been designated as the authorized representative along with the representative's name, address, and phone number. If you or your spouse is unable to provide a written statement, the Plan requires written proof (e.g., power of attorney for health care purposes, court order of guardian/conservator) that the authorized representative has been authorized to act on your or your dependent's behalf.

Once an authorized representative is named, the Plan will forward all future claims and appeals-related correspondence to the authorized representative and not to you or your dependent. The authorized representative designation is valid for one year, or as mandated by a court order, before requiring a new authorization. You or your spouse may revoke a designated authorized representative by submitting a signed statement. The Trustees, or its designated representative, has the sole discretion to determine whether you or your spouse 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.

Health Care Claim Types

There are four basic types of health care claims, which include medical, prescription drug, and dental claims:

- **Urgent Care.** A claim for medical care or treatment that:
  - Would seriously jeopardize your life or health; or
  - Would subject you to severe pain that cannot be adequately managed without care or treatment, in the opinion of a doctor with knowledge of your condition.
- **Pre-Service**. A claim for benefits where pre-certification is required. Pre-certification is required for transplant benefits, outpatient physical therapy, continuing care, mental health and chemical/substance abuse benefits, durable medical equipment, cochlear implants, and outpatient physical, occupational, and speech therapy for congenital neurological diseases for dependent children.
- **Concurrent Care.** Any request to extend the duration or number of treatments previously approved through a pre-service claim (such as re-certification of the number of pre-certified treatments for outpatient mental health).
- **Post-Service.** A claim for Plan benefits that is not an urgent care, pre-service, or concurrent care claim. When you file a post-service claim, you have already received the services in your claim.

For purposes of these claims and appeal procedures, unless otherwise noted, post-service claims include all other non-health care claims.

A request is not a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures;
- Made by someone other than the participant or his/her authorized representative;
- Made by a person who will not identify themselves (anonymous);
- A casual inquiry about benefits, such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- For prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal; and
- The presentation of a prescription that a pharmacy or mail order drug provider denies. After the denial by the pharmacy or mail order drug provider, the participant may file a claim with the Fund Office.

Filing A Claim

Urgent Care Claim

The Case Manager is responsible for providing pre-certification.

The claimant or claimant's authorized representative must contact the Case Manager for an urgent care claim. A health care professional with knowledge of the claimant's medical condition will be considered the claimant's authorized representative without receiving written authorization from the claimant. The claimant will be notified of the decision as soon as possible, but not later than 72 hours, after receipt of the urgent care claim. Notification will be oral with written notification following not later than three days after oral notification.

If the claimant does not follow the urgent care claim procedures or provides sufficient information, the claimant will be notified as soon as possible, but not later than 24 hours, after receipt of the claim. The claimant will be provided with the specific information necessary to complete the claim and allowed a minimum of 48 hours to

provide the requested information. The claimant will be notified of the decision on the claim as soon as possible, but not less than 48 hours, after the earlier of:

- Receipt of the requested information; or
- The end of the period allowed the claimant to provide the information.

Notification will be provided orally with written notification following not later than three days after the oral notification.

Pre-Service Claim

The Plan's Case Manager must be contacted on a pre-service claim before the expected date of the service for non-urgent care services. The pre-service claim will be reviewed within a reasonable period of time, but not later than 15 days, after receipt of the pre-service claim. If the claimant does not follow the pre-service claim procedures, the claimant will be notified as soon as possible, but not later than five days, after the claim is received.

The 15-day review period may be extended one time by the Administrative Manager for up to 15 additional days if the Case Manager determines that an extension is necessary due to matters beyond its control. The claimant will be notified as soon as possible, but not later than the expiration of the initial 15-day review period, of the date the decision is expected. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as inadequate information to make a decision), and any additional information needed to resolve these issues.

The claimant will be notified as soon as possible if additional information is necessary to make a decision on the claim. The claimant will have 45 days to provide the additional information. A decision will be made within a reasonable period of time, but not later than 15 days, following receipt of the additional information and the claimant will be notified orally and/or in writing (including electronic communication).

Concurrent Claim

The Case Manager will review the claimant's condition and determine whether adjustments are necessary for the approved course of treatment. The claimant will be notified of the decision to reduce or terminate treatment and allowed sufficient time to appeal the decision before the treatment is reduced or terminated. If an extension of approved urgent care treatment is requested, a determination will be made within 24 hours of the request if the request is received at least 24 hours before the treatment ends. Concurrent claims relating to an urgent care claim or a pre-service claim will be processed according to the respective time frames for an urgent care claim or pre-service claim.

Post-Service Claim

For post-service claims, you must notify the Fund Office in writing within 90 days of your illness or injury but not later than 90 days after the end of the calendar year during which the expense was incurred. For example, if you incur a claim in 2004, you must submit the claim by March 30, 2005. The Fund Office provides claim forms. If the forms are not provided within 15 days after the Fund Office receives notice of the claim, you will be considered to have complied with the time requirements for filing a claim.

If a claim cannot be processed due to insufficient information, the claimant will be notified of the information required. The claimant will have 45 days to provide the additional information. During the time the claimant has to provide the information, the time for making a decision on the claim will be suspended. The claimant will be notified of the decision within the initial or extended decision period, not including the waiting time for the additional information.

Post-service claims must:

- Be written or electronically submitted in accordance with HIPAA's (Health Insurance Portability and Accountability Act) EDI (Electronic Data Interchange) standards;
- Be received by the Fund Office within 90 days, but not later than 90 days after the end of the calendar year in which the expense was incurred;
- Name a specific individual (claimant/patient);
- Include a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service, or product for which approval or payment is requested and itemized details of the charges;
- Include the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is the primary payer, include a copy of the other plan's Explanation of Benefits (EOB) statement along with the submitted claim.

Benefit Determinations

After a claim is received, the claim will be decided within:

- 15 days for pre-service health care claims;
- 30 days for post-service health care claims;
- 45 days for disability claims; and
- 90 days for all other claims.

Upon notice to the claimant before the initial or extended period ends, the time period may be extended up to:

- 15 days for health claims (pre-service and post-service)
- Two 30-day periods for disability claims; and
- 90 days for all other claims.

Payment Of Claims

All payments will be made as soon as administratively possible after proof of a claim is received (as previously described); however, for any loss for which recurrent payments are provided, benefit amounts will be paid as they accrue, at least monthly. Payments of claims will be made either directly to the provider or to the participant.

Payment Of Death Benefit Claims

Death benefits, if any, will be paid in accordance with the applicable provisions. Any other benefits accrued but unpaid at death may be paid to the deceased person's estate or to the beneficiary.

Benefits payable to a deceased person's estate, a minor, or person who is incapacitated may be paid, at the Trustees' option, to any person who is related by blood or marriage and whom the Trustees consider eligible to receive them. This payment will fully discharge the Plan to the extent of payment any due.

Adverse Benefit Determination

An adverse benefit determination is:

- A denial, reduction, termination, or failure to provide or make payment, in whole or in part, of a benefit;
- A determination after service occurred of an individual's eligibility for benefits;
- A benefit denial resulting from any case management review or failure to cover an item or service for which benefits are otherwise provided because they are experimental, investigational, medically necessary, or appropriate; and
- Payment in accordance with the Plan, but less than the total amount of expenses submitted (e.g., application of deductible or copayment requirements).

If the claim is wholly or partially denied, a notice of this initial denial (adverse benefit determination) will be provided in writing (or electronically, as applicable) within the time frame required to make a decision on that claim. The notice of initial denial will:

- Give the specific reason(s) for the denial;
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional information needed and an explanation of why the information is necessary;
- Provide an explanation of the Plan's appeal procedure along with time limits for filing an appeal;
- Contain a statement that the claimant has the right to bring a civil action under ERISA Section 502(a) following an appeal;
- If the denial was based on an internal rule, guideline, protocol, or similar criteria, contain a statement that the rule, guideline, protocol, or criteria will be provided, free of charge, upon request;
- If the denial was based on a medical judgment (medical necessity, experimental, or investigational), contain a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided, free of charge, upon request; and
- If the claim is denied and the claimant disagrees with that decision, contain a statement that the claimant or the claimant's authorized representative may make an appeal request for review of the decision.

A claimant's appeal must be filed within specified time frames in accordance with the type of claim involved. Appeals will not be accepted after the specified time frames, as described below.

Appeal Procedures

After receipt of the adverse benefit determination, appeals must be submitted within 180 days for health and disability claims or 60 days for all other for claims. The Plan maintains a two-level appeal process for pre-service and post-service health care claims. The Trustees have delegated fiduciary responsibility for pre-service and post-service health care claims determination to the Review Panel. The Review Panel is responsible for all initial and second level appeal determinations. The Review Panel will meet at regularly scheduled times.

A health care professional with appropriate training and experience will be consulted when reviewing an adverse benefit determination that is based on a medical judgment (such as a determination that a service is not medically necessary or is experimental or investigational).

The claimant has the right to review documents relevant to the claim and to submit their own comments in writing. If the claim was denied due to a medical judgment (medical necessity, experimental, or investigational), a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial nor the subordinate of any such individual will be consulted.

Initial Appeal

Appeals must be submitted in writing to the Fund Office, except in the case of an urgent care claim or pre-service claim. Appeals for urgent care and pre-service claims may be handled verbally. The claimant will be provided with:

- Upon request and without charge, reasonable access to and copies of all relevant documents, records, and other information relevant to the claim for benefits;
- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- A full and fair review that takes into account all comments, documents, records, and other information submitted, without regard to whether the information was submitted or considered in the initial benefit determination; and
- A review that does not defer to the initial determination and that is not conducted by the individual who made the initial determination that is the subject of the appeal, nor the subordinate of the individual.

In deciding an appeal that is based, in whole or in part, on medical judgment, including whether a particular treatment, drug, or other item is experimental, investigational, medically necessary, or appropriate, the appropriate named individual:

- Will consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment;
- Is not the individual who was consulted in connection with the initial determination that is the subject of the appeal nor the subordinate of the individual; and
- Will provide upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan without regard to whether the advice was relied upon in making the initial determination.

Appeals will be decided as soon as possible, but no later than:

- 15 days for a pre-service health care claim (for initial appeal);
- 30 days for a post-service health care claim (for initial appeal);
- 45 days for a disability claim; or
- 60 days for all other claims (other than a health care or disability claim).

If a 45-day extension for a disability claim or a 60-day extension for all other claims (other than a health care or disability claim) is necessary, the claimant will be notified why the extension is necessary and the date a decision on the appeal is expected.

Second-Level Appeal

If an 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 Fund Office. Appeals must be submitted within 180 days after receipt of the adverse benefit determination.

Second-level appeals will be decided as soon as possible, but no later than:

- 15 days for a pre-service health care claim (for second-level appeal); or
- 30 days for a post-service health care claim (for second-level appeal).

Appeal Determinations

The written appeal determination will include:

- The specific reason(s) for the appeal review decision;
- Reference to the specific Plan provision(s) on which the denial is based;
- A statement that the claimant is entitled to receive upon request, free access to and copies of documents relevant to the claim;
- A statement that the claimant has the right to bring a civil action under ERISA Section 502(a) following the appeal;
- If the denial was based on an internal rule, guideline, protocol, or similar criteria, a statement that the rule, guideline, protocol, or criteria will be provided free of charge, upon request; and
- If the denial was based on a medical judgment (medical necessity, experimental, or investigational), a statement that the scientific or clinical judgment will be provided free of charge, upon request.

The Plan does not offer any further voluntary appeal process.

Claim Filing And Appeal Process Summary

	Urgent Care	Concurrent Care	Pre-Service	Post-Service Health Care	Disability	All Other
Initial benefit determination must be made as soon as possible, but not later than:	72 hours	Before the benefit is reduced or treatment is terminated	15 days	30 days	45 days	90 days
Is an extension permitted during initial benefit determination?	No	No	Yes, up to 15 days	Yes, up to 15 days	Yes, up to 2 30-day extensions	Yes, up to 90 days
Appeal must be submitted within:	180 days	180 days	180 days	180 days	180 days	60 days
Appeal determination must be made as soon as possible, but not later than:	72 hours	Before the benefit is reduced or treatment is terminated	15 days for each level of appeal	30 days for each level of appeal	45 days	60 days
Is an extension permitted during appeal review?	No*	No*	No*	No*	Yes, up to 45 days	Yes, up to 60 days

** While the Plan may not automatically extend the time period for a determination on appeal, the time may be extended if the participant agrees in advance to an extension.*

Plan A Schedule Of Benefits Effective January 1, 2006

Comprehensive Medical Benefits[1]	***Special Limits, If Any***
Calendar Year Benefit Maximum	$ 50,000 + balance of $750,000 Supplemental Lifetime Fund
Calendar Year Deductible	$300 per person (limited to $700 per family)
Calendar Year Out-of-Pocket Maximum	$2,500 per person (limited to $6,000 per family)
Routine Physical Exam (For members and their dependent spouses)	Plan pays 100%, not subject to deductible, up to $350 per person in a Calendar Year
Well-Baby Care (for eligible newborn dependent children to age 2)	Plan pays 100%, not subject to deductible up to $2,000 lifetime
The following benefits are paid as follows: In-Network (PPO Provider): Out-of-Network (Non-PPO Provider): Benefits are paid once the calendar year deductible is met and are paid at 100% after the out-of-pocket limit is met.	 90% 80%
Hospital Room and Board and Miscellaneous Expenses	Private room only if medically necessary (i.e., contagious diseases)
Outpatient Surgical Charges	Charges for surgical supplies are included in the physician's fee
Physician's Care	
Pre-Admission Testing	Within 14 days of hospitalization
Second Surgical Opinion	From a Board-Certified surgeon or specialist
MRIs/CT Scans	Paid at 100%, after deductible is satisfied, if Medlink is used
Kidney Dialysis	Must be administered on an outpatient basis
Chemotherapy/Radiation Therapy	Must be administered on an outpatient basis
Organ/Tissue Transplants Lifetime Maximum Organ/Tissue Procurement Transportation & Lodging Private Nursing Care	Must be pre-certified and in-network only; out-of-network charges are not covered $300,000, including up to: $25,000 $10,000 $10,000
Convalescent Care	Coverage limited to 45 days per spell of illness, other limitations apply
Continuing Care	When approved by Case Manager only
Outpatient Physical Therapy	When approved by Case Manager only
Medical Orthodontics	When approved by Case Manager only
Mental Health and/or Substance Abuse Treatment	You must use a ComPsych provider; otherwise, charges are not covered
Inpatient	In-network only; coverage limited to 30 days per lifetime
Outpatient	In-network only; coverage limited to 60 visits per lifetime
The following special coverages are paid at 80% and are not subject to the calendar year deductible unless otherwise noted.	
Medical Equipment Wheelchair Lifetime Maximum	If you pre-certify Durable Medical Equipment; paid at 50% if not pre-certified $15,000
Treatment for Congenital Neurological Diseases for dependent child to age 19 including physical, occupational, and speech therapy	Subject to calendar year deductible; limited to $5,000 per calendar year when approved by a Case Manager only.
The following special coverages are paid at 50% and are not subject to the calendar year deductible unless otherwise noted.	
Temporomandibular Joint Syndrome Orthodontics (TMJ)	Maximum lifetime benefit for each eligible person of $2,500
Orthoptic Training (for dependent children up to age 10)	Subject to the calendar year deductible; limited to 40 visits per lifetime
Rehabilitation Speech Therapy (for a child ages 2 – 5)	Subject to calendar year deductible

[1] *Eligible expenses must be medically necessary and are subject to reasonable and customary limits.*

Prescription Drug Program

The Prescription Drug Program covers eligible prescription drug expenses when you fill your prescription at the Midwest Benefit Pharmacy or at any network pharmacy for emergency prescriptions only. The Program's benefits are highlighted below and are explained in more detail in your Summary Plan Description.

Calendar Year Maximum	$15,000 per person
At the Midwest Benefit Pharmacy: Walk in, call or mail	
Monday, Tuesday, Wednesday, Friday	8:00 a.m. to 6:00 p.m.
Thursday	8:00 a.m. to 7:00 p.m.
Saturday	8:00 a.m. to 12:00 p.m.
Copayment	
Generic[2]	You pay $5
Brand-name	
• Up to a 30-day supply	You pay $5
• Up to a 60-day supply	You pay $10
• Up to a 90-day supply	You pay $15
Hepatitis C Initial Course of Treatment Maximum	$40,000 during a 12-month period
Dispensing Limitations	
• New Medications	Up to a 30-day supply
• Refills	Up to a 90-day supply
• Schedule II Medications	Up to a 30-day supply
• Diabetic Test Strips & Lancets	Up to a 100-unit (30-day) supply
Mail Order Service	The Pharmacy will mail your prescription to your home via First Class Mail, Certified Mail, or UPS.
At Any Network Pharmacy (emergency medication up to a 15-day supply)	You pay 20% of the cost of covered prescriptions at the pharmacy
At Any Non-Network Pharmacy	Not covered
At Any Convalescent/Nursing Home	Plan reimburses you for 50% of covered prescriptions

[2] *Unless your physician specifies "do not substitute" on your prescription, all scripts will be filled with generics, whenever a generic substitute is available. If you request a brand name medication when a generic is available, you are responsible for paying the brand name copayment plus the difference in cost between the brand name and generic.*

Dental Plan

The Plan's benefits are based on a Maximum Allowable Fee Table. Your dental benefits are highlighted below and are explained in more detail in your Summary Plan Description. Only eligible expenses that are medically necessary are covered.

Calendar Year Maximum Benefit	$1,000 per person
Dental Copayment	
Preventive Services	Plan pays 100%, limited to two times each year (not subject to Maximum Allowable Fee)
Basic and Restorative Services	Plan pays 70%
Orthodontics (children under age 19)	Plan pays 50% up to a lifetime maximum benefit amount of $1,500 per covered child
Dental PPO Network	You can save money on your out-of-pocket dental care costs when you go to a First Commonwealth/Guardian Preferred Provider Organization (PPO) Network dentist. Call (888) 600-9200 for a network dentist near you.

Family Supplemental Benefit

Family Calendar Year Maximum	$1,500

Non-Occupational Weekly Disability Benefit (Active Employees Only)

Benefit Amount	$250 per week for up to 52 weeks
When Benefits Begin	First day of accident or illness, provided disability lasts at least eight days

Death Benefit

Benefit Amount	
Active Employees	$30,000 (Limited to $7,500 for Active Employees of the City of Chicago)
Eligible Dependents	$ 2,000

Accidental Dismemberment Benefit (Active Employees Only)

Benefit Amount	$5,000 or $1,000 based on type of loss; limited to $10,000 per occurrence

Plan C Schedule Of Benefits Effective January 1, 2006

Comprehensive Medical Benefits[1]	***Special Limits, If Any***
Calendar Year Benefit Maximum	$50,000 + balance of $200,000 Supplemental Lifetime Fund
Calendar Year Deductible	$100 per person (limited to $300 per family)
Calendar Year Out-of-Pocket Maximum	$2,500 per person (limited to $6,000 per family)
Coinsurance In-Network (PPO Provider): Out-of-Network (Non-PPO Provider): Services and Supplies Not Provided In-Network (such as durable medical equipment, ambulance) Benefits are paid once the calendar year deductible is met and are paid at 100% after the out-of-pocket limit is met.	Must be in-network only 90% 0% 70%
Well-Baby Care (for eligible newborn dependent children to age 2)	Plan pays 100%, not subject to deductible up to $2,000 lifetime
Hospital Room and Board and Miscellaneous Expenses	Private room only if medically necessary (i.e., contagious diseases)
Outpatient Surgical Charges	Charges for surgical supplies are included in the physician's fee
Physician's Care	
Pre-Admission Testing	Within 14 days of hospitalization
Second Surgical Opinion	From a Board-Certified surgeon or specialist
MRIs/CT Scans	Paid at 90%, after deductible is satisfied, if Medlink is used
Kidney Dialysis	Must be administered on an outpatient basis
Chemotherapy/Radiation Therapy	Must be administered on an outpatient basis
Organ/Tissue Transplants Lifetime Maximum Organ/Tissue Procurement Transportation & Lodging Private Nursing Care	Must be pre-certified and in-network only; out-of-network charges are not covered $250,000, including up to: $25,000 $10,000 $10,000
Foot Orthotics	Coverage limited to $300 per person per year up to a lifetime maximum of $1,500 per person
Convalescent Care	Coverage limited to 45 days per spell of illness, other limitations apply
Continuing Care	When approved by Case Manager only
Outpatient Physical Therapy	When approved by Case Manager only
Medical Orthodontics	When approved by Case Manager only
Treatment for Congenital Neurological Diseases for dependent child to age 19 including physical, occupational, and speech therapy	Subject to calendar year deductible; limited to $5,000 per calendar year when approved by a Case Manager only.
The following special coverages are paid at 70% and are not subject to the calendar year deductible unless otherwise noted.	
Medical Equipment Wheelchair Lifetime Maximum	If you pre-certify Durable Medical Equipment; paid at 50% if not pre-certified $15,000
The following special coverages are paid at 50% and are not subject to the calendar year deductible unless otherwise noted.	
Temporomandibular Joint Syndrome Orthodontics (TMJ)	Maximum lifetime benefit for each eligible person of $2,500
Orthoptic Training (for dependent children up to age 10)	Subject to the calendar year deductible; limited to 40 visits per lifetime
Rehabilitation Speech Therapy (for a child ages 2 – 5)	Subject to calendar year deductible

[1] *Eligible expenses must be medically necessary and are subject to reasonable and customary limits.*

Prescription Drug Program

The Prescription Drug Program covers eligible prescription drug expenses when you fill your prescription at the Midwest Benefit Pharmacy or at any network pharmacy for emergency prescriptions only. The Program's benefits are highlighted below and are explained in more detail in your Summary Plan Description.

Calendar Year Maximum	$7,500 per person
At the Midwest Benefit Pharmacy: Walk in, call or mail	
Monday, Tuesday, Wednesday, Friday	8:00 a.m. to 6:00 p.m.
Thursday	8:00 a.m. to 7:00 p.m.
Saturday	8:00 a.m. to 12:00 p.m.
Copayment per 30-day supply:	
Generic[2]	You pay $5
Brand-name	You pay $10 *If you request a brand name medication when a generic is available, you are responsible for paying the brand name copayment plus the difference in cost between the brand name and generic.*
Hepatitis C Initial Course of Treatment Maximum	$40,000 during a 12-month period
Dispensing Limitations	
• New Medications	Up to a 30-day supply
• Refills	Up to a 90-day supply
• Schedule II Medications	Up to a 30-day supply
• Diabetic Test Strips & Lancets	Up to a 100-unit (30-day) supply
Mail Order Service	The Pharmacy will mail your prescription to your home via First Class Mail, Certified Mail, or UPS.
At Any Network Pharmacy (emergency medication up to a 15-day supply)	You pay 20% of the cost of covered prescriptions at the pharmacy
At Any Non-Network Pharmacy	Not covered
At Any Convalescent/Nursing Home	Plan reimburses you for 50% of covered prescriptions

[2] *Unless your physician specifies "do not substitute" on your prescription, all scripts will be filled with generics, whenever a generic substitute is available.*

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