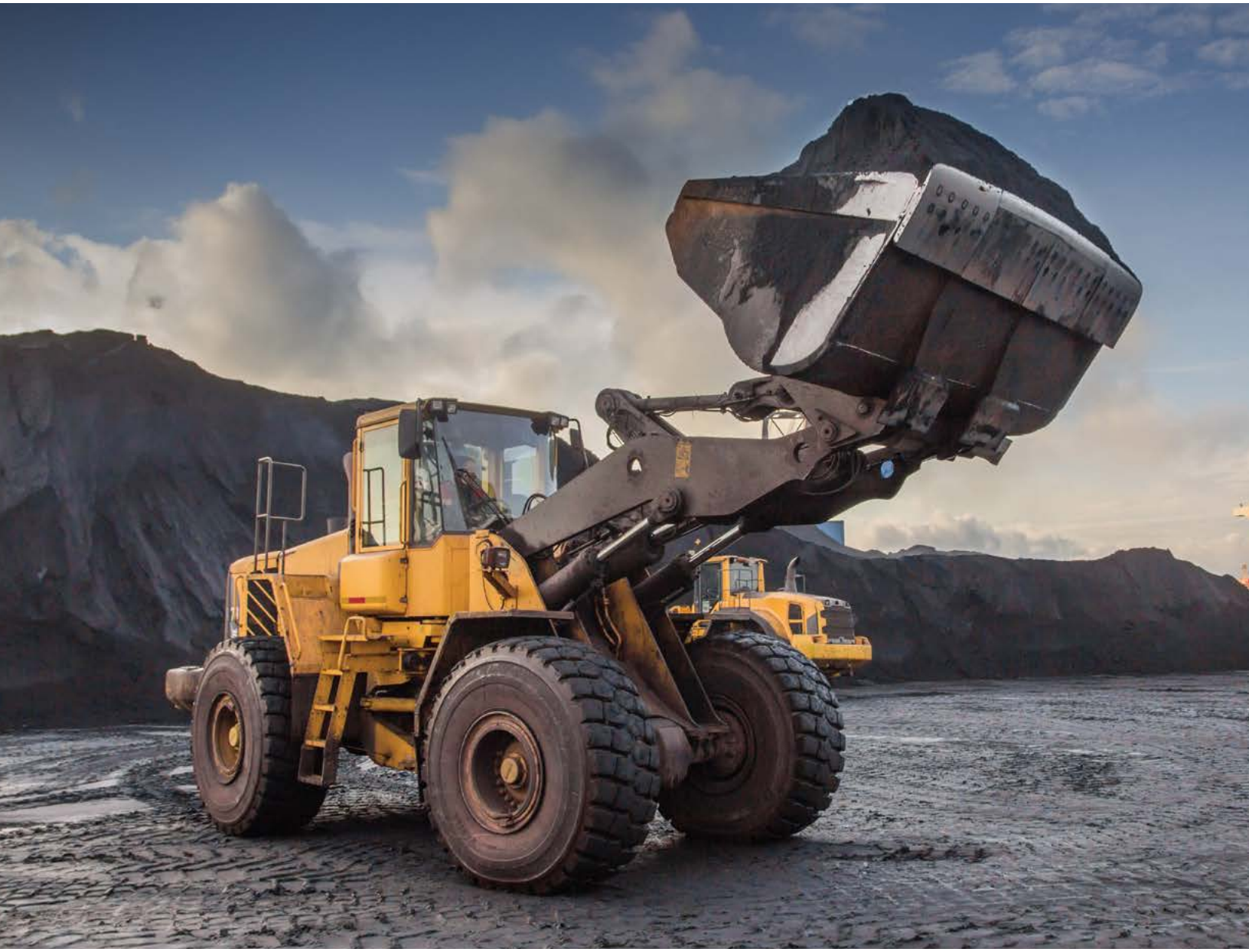
2024
Summary Plan Description



WELFARE FUND *of the* INTERNATIONAL UNION OF OPERATING ENGINEERS

LOCAL 15, 15A, 15C & 15D, AFL-CIO

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INTRODUCTION

The Board of Trustees of the Welfare Fund of the International Union of Operating Engineers Local 15, 15A, 15C & 15D, AFL-CIO ("Local 15 Welfare Fund" or "Plan") is pleased to present you with this new Summary Plan Description ("SPD") which highlights the various benefits available to you and your eligible dependents effective as of [DATE] including medical, prescription drugs, dental, vision, disability, and death. The Plan is financed completely by contributions made by Contributing Employers pursuant to the collective bargaining agreements negotiated by the International Union of Operating Engineers Local 15, 15A, 15C & 15D, AFL-CIO.

This SPD replaces all other SPDs that have been previously provided to you. Please read this SPD carefully and maintain this document for future reference. This document will help you understand the benefits provided by the Local 15 Welfare Fund. We have tried to organize the information in this SPD in a way that will be useful to you and if you are not familiar with any of the terms used in this booklet, please check the Definitions section at the back of this SPD. Generally, terms identified in the Definition section are capitalized throughout the SPD.

If you have any questions, please contact the Fund Office by telephone at (212) 255-7657 or in writing at 44-40 11th Street, Long Island City, New York 11101. You may also find us on the web at iuoelocal15.org.

Sincerely,

The Board of Trustees

James T. Callahan

Thomas A. Callahan

William Tyson

Michael Salgo

IMPORTANT CONTACT INFORMATION

When you need information, please check this document first. If you need further help, call or write to the contact listed below.

INFORMATION NEEDED	WHOM TO CONTACT
General Plan Information and Eligibility • Eligibility • Enrollment • Request documents or other Plan related information • Replacement ID Cards • General questions about Plan coverage (Information COBRA Continuation of Health Coverage **Dental and Vision Benefits** • Claims and Appeals **Death Benefits** • Claim application • Claims and Appeals **HIPAA Privacy and Security Officer**	**Welfare Fund of the International Union of Operating Engineers Local 15, 15A, 15C & 15D, AFL-CIO** 44-40 11th Street Long Island City, New York 11101 iuoelocal15.org (forms are available) (212) 255-7657
Participating Provider Organization **In-Network Medical and Hospital Benefits** • Precertification • Claims and Appeals • Plan Benefit Information • Medical PPO Providers • Additions/Deletions of Network Providers **Non-Participating Provider/Out-of-Network Benefits** • Precertification • Claims and Appeals **Plan Benefit Information**	**Anthem Blue Cross Blue Shield PPO** *(formerly known as Empire BlueCross BlueShield PPO)* Participant Services P.O. Box 1407 Church Street Station New York, NY 10008-1407 www.anthembluecross.com 844-243-5566 TDD for hearing impaired: 800-682-8786 Medical Management: 800-982-8089 **Mental Health and Substance Use Disorder Benefits** Precertification: 800-626-3643 Por favor permanezca en la línea y espere que la grabación termine. Un representante de servicios a los miembros contestará la línea y le conectará con un traductor 800-342-9816

INFORMATION NEEDED	WHOM TO CONTACT
Prescription Drug Program • Identification (ID) Cards • List of Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Formulary of Preferred Drugs • Precertification of Certain Drugs • Direct Participant Reimbursement (for Non-network retail pharmacy use) **Specialty Drug Program: Precertification and Ordering**	**OptumRx** P.O. Box 650334 Dallas, TX 75265-0334 855-295-9140 www.optum.com OptumRx Specialty Pharmacy 855-427-4682
Weekly Loss of Time Benefit (Short Term Disability) Benefits New York State Paid Family Leave Benefit	**The Union Labor Life Insurance Company** 8403 Colesville Road Silver Spring, MD 20916 888-855-4261 Initial Claims should be mailed to the Fund Office and will be forwarded to ULLICO.

ELIGIBILITY FOR COVERAGE

Eligibility For Active Participants

You are eligible for coverage described in this Booklet if you are employed in Covered Employment, which is work in a job category covered by a Collective Bargaining Agreement with the International Union of Operating Engineers Local 15, 15A, 15C & 15D, AFL-CIO ("Local 15"), which requires that contributions be made to the Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C & 15D, AFL-CIO ("Local 15 Welfare Fund", "Fund" or "Plan"). Coverage under the Plan is divided into three Benefit Periods: January through April; May through August; and September through December. Coverage is determined based upon the number of hours you work in covered employment and based upon the number of hours in fringe benefit contribution stamps you redeem during each of the Redemption Periods identified below.

The Stamp Redemption Process

You will receive stamps for the hours you work in covered employment from your contributing employer. You are required to redeem these fringe benefit stamps during each of the Redemption Periods that pre-date the Benefit Periods as described below:

REDEMPTION PERIOD	BENEFIT PERIOD
November through December	January through April
March through April	May through August
July through August	September through December

As described hereafter, depending upon the number of hours redeemed during a Redemption Period, you may be entitled to coverage for one, two or three Benefit Periods.

Initial Eligibility

New Participants and those being reinstated from "suspended status" or "withdrawal status" must work and redeem the following number of hours in order to be eligible for benefits during a Benefit Period as described above.

LOCAL DIVISION/STATUS/CONTRACTOR	YOU WILL BE ENTITLED TO ONE BENEFIT PERIOD ONCE YOU WORK AT LEAST THE FOLLOWING NUMBER OF HOURS:
Local 15 and 15A (also applies to those working on permit within the jurisdiction of Local 15, 15A)	700 hours of unit work
Local 15 and 15A Apprentice	700 hours of unit work
Local 15 and 15A Cement	727 hours of unit work

Local Division/Status/Contractor	You Will Be Entitled To One Benefit Period Once You Work At Least The Following Number Of Hours:
Local 15 BCA/CAGNY	714 hours of unit work
Local 15, 15A, 15C or 15D Owner Operator	700 hours of unit work
Local 15C Equipment	840 hours of unit work
Local 15 GCA	807 hours of unit work
Local 15 GCA B-Helper	862 hours of unit work
Local 15C (Stewart & Stevenson)	808 hours of unit work
Local 15C (HO Penn)	804 hours of unit work
Local 15C (XVES)	804 hours of unit work
Local 15C Sims Hugo Neu	1060 hours of unit work
Local 15C Small Tool	859 hours of unit work
Local 15C Komatsu/Ehrbar	804 hours of unit work
Local 15D GCA	700 hours of unit work
Local 15D BCA, CAGNY	714 hours of unit work
Local 15D Allied Steel	700 hours of unit work
Local 15D Consultant/Surveyor	851 hours of unit work
Local 15D Nelson & Pope	1031 hours of unit work
Local 15D Cement	727 hours of unit work
Local 15G	887 hours of unit work
Local 15H (SBIB)	972 hours of unit work
Local 15 (RMR)	791 hours of unit work
Local 15 DMR	714 hours of unit work
Covanta	772 hours of unit work
Hudson Valley	879 hours of unit work
Weeks Marine	772 hours of unit work

Start of Coverage Following Initial Eligibility

Once the initial eligibility requirement is met, benefits begin on the first day of the first month of the following Benefit Period. Initial coverage will be for one Benefit Period only. Once you meet the eligibility requirements, you are considered a "Participant" in the Fund.

Continuing Eligibility

Thereafter, once you have met the initial eligibility requirements as described above, the number of hours worked for which stamps are distributed to you and to be redeemed, are required for continued eligibility as follows. Please note that you must redeem stamps attributable to the hours worked during the period earned (which is July 1st of a given year through June 30th of the following year) and eligibility is calculated based on the hours submitted in stamps during that Redemption Period. Coverage will not overlap.

Number of Hours of Unit Work Required for:

Local Division/Status/ Contractor	One Benefit Period (4 Months Of Coverage)	Two Benefit Periods (8 Months Of Coverage)	Three Benefit Periods (12 Months Of Coverage)
Local 15 and 15A (also applies to those working on permit within the jurisdiction of Local 15, 15A)	250 hours	475 hours	750 hours
Local 15 and 15A BCA CAGNY	255 hours	484 hours	765 hours
Local 15 and 15A Apprentice	250 hours	475 hours	750 hours
Local 15 and 15A Cement	260 hours	494 hours	779 hours
Local 15, 15A, 15C and 15D Owner Operator	680 hours	N/A	N/A
Local 15C Equipment	300 hours	570 hours	900 hours
Local 15 GCA	289 hours	548 hours	865 hours
Local 15 GCA B-Helper	308 hours	585 hours	924 hours
Local 15C (Stewart & Stevenson)	289 hours	548 hours	865 hours
Local 15C (HO Penn)	289 hours	546 hours	862 hours
Local 15C (XVES)	289 hours	546 hours	862 hours
Local 15C Sims Hugo Neu	379 hours	720 hours	1136 hours
Local 15C Small Tool	307 hours	583 hours	920 hours
Local 15C Komatsu/Ehrbar	287 hours	545 hours	861 hours
Local 15D GCA	250 hours	475 hours	750 hours
Local 15D BCA CAGNY	255 hours	484 hours	765 hours
Local 15D Allied Steel	250 hours	475 hours	750 hours
Local 15D Consultant/Surveyor	304 hours	578 hours	912 hours
Local 15D Nelson & Pope	369 hours	700 hours	1105 hours

Local Division/Status/ Contractor	One Benefit Period (4 Months Of Coverage)	Two Benefit Periods (8 Months Of Coverage)	Three Benefit Periods (12 Months Of Coverage)
Local 15D Cement	260 hours	494 hours	779 hours
Local 15G	317 hours	602 hours	950 hours
Local 15H (SBIB)	348 hours	660 hours	1042 hours
Local 15 DMR	255 hours	484 hours	765 hours
Local 15 (RMR)	283 hours	537 hours	847 hours
Covanta	276 hours	524 hours	827 hours
Hudson Valley	314 hours	596 hours	941 hours
Weeks Marine	276 hours	524 hours	827 hours

Credit for Eligibility Based Upon Overtime Hours

For all eligible participants, credit for eligibility for overtime hours will be calculated in accordance with the rate contributed. For instance, if the Collective Bargaining Agreement you work under calls for a single time contribution to be made for any overtime hour worked, your eligibility for the overtime will count as one straight time hour.

Very Important: The total hourly contribution received within a Redemption Period will determine your initial eligibility and continued eligibility under the Plan. Therefore, it is imperative that you:

- review the hourly eligibility requirements carefully as they are not universal and can differ substantially by Collective Bargaining Agreement or if you are an Owner Operator, and
- redeem the benefit stamps that are in your possession during each and every Redemption Period.

Note: Redemption of stamps from prior periods that have an hourly rate less than the highest rate in effect at the time of redemption will be pro-rated for the hourly calculation of your eligibility requirements.

Owner/Operator Eligibility

Local 15 Participants who are owner/operators will only be eligible for benefits under the Local 15 Welfare Fund if they contribute the required number of hours in fringe benefit stamps during each Redemption Period which is 680 hours per Redemption Period. Failure to contribute the required number of hours in any Redemption Period will result in the loss of eligibility for coverage under this Plan for the subsequent 4-month Benefit Period.

Union and Fund Office Staff Eligibility

Union and Fund Office Staff are subject to an initial probationary period of 90 days of full-time work. Once this probationary period is met, coverage begins the first of the month and is retroactive to the initial date of hire.

Reciprocity of Eligibility

The Local 15 Welfare Fund has a reciprocal agreement with the welfare funds of the local union members of the Northeastern District of the International Union of Operating Engineers. This agreement was established in order to preserve eligibility and to provide continuity of medical coverage for you as a participant in your home local's welfare fund, regardless of where you may work in the Northeastern District, provided you are working for a contributing employer doing unit work within the jurisdiction of the out-of-town local and in accordance with its collective bargaining agreements.

Participants may not establish initial eligibility in this Fund by means of reciprocity hours. (Hours earned under another health fund with which this Plan has made arrangements for the transfer of contributions).

The Northeastern District of the International Union of Operating Engineers includes the following Welfare Funds:

- Local 4 (Boston, MA)
- Local 14 (Flushing, NY)
- Locals 17 (Upstate New York)
- Local 158, 106, 463, 545, and 832 (Upstate New York)
- Local 25 (Brooklyn, NY)
- Local 57 (Providence, RI)
- Local 66 (Pittsburgh, PA)
- Local 98 (Springfield, MA)
- Local 137 (Briarcliff Manor, NY)
- Local 138 (Nassau & Suffolk Counties, NY)
- Local 478 (Hamden, CT)
- Local 542 (Philadelphia, PA)
- Local 825 (Newark, NJ and Newburgh, NY)

Note: The Local 15 Welfare Fund reserves the right to prorate hours if your home local's welfare fund's contribution rate is lower than the contribution rate currently in effect under any of the Local 15 negotiated Collective Bargaining Agreements. Participants are reminded of their obligation to contact the Fund Office immediately upon acceptance of work as an Operating Engineer outside of Local 15's jurisdiction.

Eligibility for weekly loss of time benefit

Every participant is eligible to receive weekly loss of time benefits upon employment with a contributing employer in accordance with applicable state law provided they performed unit work under the jurisdiction of Local 15 and provided they are not receiving unemployment or workers compensation benefits at the same time. Please refer to the section of this booklet entitled "Weekly Loss of Time Benefits" for details as to how the benefit works.

Dependent Eligibility

Your Dependents are eligible for Plan coverage when you are eligible provided you enroll them. When you lose eligibility, your Dependents will also lose their eligibility for coverage. Your Eligible Dependents include:

- The spouse to whom you are legally married.
- Any of your children, whether married or unmarried, as listed below, who are under the age of 26 up until the end of the month in which they turn age 26. "Child" includes:
    - Natural Children.
    - Stepchildren (so long as a natural parent remains married to you).
    - Legally Adopted Children and Children Placed with You for Adoption (from the start of any waiting period prior to the finalization of the child's adoption). Also includes a newborn infant who is adopted by you from the moment you take physical custody of the child upon the child's release from the hospital prior to the finalization of the child's adoption. Placed for adoption means the assumption and retention by the Participant of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement for adoption terminates upon the termination of such legal obligation.
    - This Plan does not cover foster children, children for whom you are the legal guardian, or children or spouses of Dependent Children or Children of Dependent Children (grandchild of a Participant).
- Disabled Children who are age 26 or older, totally disabled prior to reaching age 19, and primarily supported by you and incapable of self-sustaining employment because of mental or physical disability. In order to qualify for this extension, required proof, including proof that the disabling condition started before age 19, must be provided to the Fund Office prior to the Child reaching age 26. See the Enrollment section for details on the process.
- Children Covered by a Qualified Medical Child Support Order (QMCSO) or National Medical Support Order (NMSO). A copy of the Plan's QMCSO's procedures can be found on page 18.
- Your Mother and/or Father (as long as you are (1) an active Participant; (2) not married or never divorced; (3) you provide more than half the financial support for your mother and/or father; and (4) you declare your mother and/or father as dependents on your federal income tax return in the year preceding the date of the service for which you are claiming benefits).

Eligibility for Continued Coverage for the Eligible Dependents of an Active Deceased Participant

As long as the Participant had coverage at the time of death, coverage for Welfare Fund benefits will be extended to all surviving Covered Dependents for a period of 36 months from the date of death of the Participant.

Coverage will be determined in the following manner:

1. Benefits for spouses who have not attained the age of 62 will be paid in the same way as Active Participants as described in this Booklet.
2. Benefits for surviving spouses who have attained the age of 62 will be paid under the Retiree Plan in accordance with the provisions found in the Retiree Benefits Booklet in the section entitled "Benefits and Provisions for Retired Participants and their Eligible Dependents Who are Not Eligible for Medicare Benefits."
3. Benefits for surviving spouses aged 65 or older who are eligible for Medicare will be paid under the Retiree Plan in accordance with the provisions found in the Retiree Benefits Booklet in the section entitled "Benefits and Provisions for Pensioned Participants and their Eligible Dependents Who are Eligible for Medicare Benefits". Such coverage under the Plan will be coordinated with Medicare regardless of whether or not the surviving spouse is enrolled in Medicare.

Coverage for any eligible dependent child of a Participant who at the time of death had medical benefits will be determined in the following manner:

- Benefits for the dependent of Active participants who have not attained their 26th birthday will be paid in the same way as Dependents of Active Participants.
- Benefits will only be paid for a maximum of 36 months, or until the dependent's 26th birthday, whichever comes first.

Eligibility for Continued Coverage for the Eligible Dependents of a Retired Deceased Participant

As long as the Participant had coverage at the time of death, coverage for Welfare Fund benefits will be extended to the surviving spouse, handicapped children and eligible dependents until the end of the month in which they turn age 26 for a period of 36 months from the date of death of the Participant.

Coverage will be determined in the following manner for any eligible dependent child of a Participant who at the time of death had retiree benefits without Medicare benefits or retired benefits with Medicare benefits:

- Upon attaining the age of 65 or becoming Medicare eligible, whichever is first, the benefits for the surviving spouse will be those that can be found in the section of the Retiree Benefits Booklet section entitled "Benefits and Provisions for Pension Participants and their Eligible Dependents Who are Eligible for Medicare Benefits".

- Benefits for eligible dependent children of Retired Participants that have not attained their 26th birthday will be paid according to the above provision entitled "Benefits and Provisions for Pension Participants and their Eligible Dependents Who are Not Eligible for Medicare Benefits."

Benefits will only be paid for a maximum of 36 months, or until the end of the month in which the Dependent turns age 26, whichever comes first.

Effective Date of Coverage for Eligible Dependents

If you have Eligible Dependents when you first become eligible for coverage, the effective date of coverage for your Eligible Dependents is the same day as yours, subject to the enrollment rules described in the following section. If you later add an Eligible Dependent, coverage will be effective when you add your new Dependent, subject to the enrollment rules described in the Enrollment section.

ELIGIBILITY RULES FOR RETIRED PARTICIPANTS

The Local 15 Welfare Fund sponsors a separate and stand-alone retiree plan for retired Participants who meet the eligibility rules as described below. The health and welfare benefits available to those retired Participants satisfying any one of the categories described hereafter are found in the summary plan description for the "Local 15 Welfare Fund Retiree Plan" which will be provided to you upon a determination of eligibility by the Plan Administrator together with other information about the Retiree Plan. Please contact the Fund Office if you would like a copy of the Retiree Plan SPD or have questions about retiree benefits.

Please note that when you retire, you will be offered COBRA continuation coverage as an alternative to Retiree benefits. If you do not elect COBRA when you first retire, you will lose your rights to COBRA. However, your Dependents may be eligible for COBRA if they experience a qualifying event while covered under the Retiree Plan. See the Retiree Plan Booklet for details on how this provision works.

Participant Who Retires on a Regular Pension

If you retire on a Regular Pension from the Central Pension Plan of the International Union of Operating Engineers ("Central Pension Fund"), you and your eligible Dependents will be entitled to health and welfare benefits from the Retiree Plan, provided you are age 62 or older; and meet one of the following criteria:

1. you have 25 years of vested pension credits at the time you apply for retirement; or
2. you have at least 10 years of vested pension credits and have accumulated at least 1,000 hours of pension credits per year during three of the last five successive years immediately prior to your date of retirement.

Participant Who Retires on an Early Retirement Pension

If you retire on an Early Retirement Pension, your coverage with this Plan will cease upon the normal cessation of the Benefit Period you are covered under at the time of Early Retirement approval from the Central Pension Fund.

You will be reinstated into the Plan and entitled to receive the benefits that are outlined in the Retiree Benefits Booklet entitled, "Benefits and Provisions for Pension Participants and their Eligible Dependents Who are Eligible for Medicare Benefits" at age 65 and entitled to receive Medicare if you meet the following requirements:

1. you had 25 years or more of vested pension credits;
2. you were covered for medical benefits by the Local 15 Welfare Fund at the time you were approved for an early retirement pension by the Central Pension Fund; and
3. you are 65 years or older, and Medicare eligible.

Your Spouse will be entitled to the same benefits as you when he or she attains age 65 and becomes entitled to Medicare.

Participant Who Retires on a Disability Pension/Awarded a Social Security Disability

If you are awarded a Social Security disability benefit while you are a covered Participant, you and your eligible Dependents are entitled to certain benefits provided you meet the following criteria:

1. you have 15 years of contributions of at least 1000 hours per year into the Local 15 Welfare Fund;
2. you were covered under this Plan at the time you were awarded a Social Security disability;
3. you were covered under this Plan during each Benefit Period in three of the five successive years immediately prior to the onset date of your disability; and
4. the Central Pension Fund, in connection with such permanent and total disability, awarded you a pension while you were covered under this Plan.

Participants wanting to avail themselves of this benefit must submit a copy of their Social Security Disability award to the Plan Administrator. The award must state that the onset of your disability occurred prior to your original eligibility termination date with the Plan. The benefits you will be entitled to receive are those that are outlined in the section of the SPD entitled "Benefits and Provisions for Pension Participants and their Eligible Dependents Who are Not Eligible for Medicare Benefits". The Fund will provide these benefits until such time that you or your eligible dependents become Medicare or Medicaid eligible. At that time the benefits you will be eligible to receive will be those that are outlined in the section of this SPD titled "Benefits and Provisions for Pension Participants and their Eligible Dependents Who are Eligible for Medicare Benefits".

Note: If you are electing this provision, please make sure that you update both your enrollment and beneficiary information, as well as complete a new authorized representative form.

Participants Entitled to Medicare Benefits (and Cease to Be Actively Working)

For Medicare eligible Participants who have earned enough hours to meet the eligibility requirements for an active Participant but cease to be actively employed by a contributing employer within the jurisdiction of Local 15, Medicare will be considered your primary insurer and the Local 15 Welfare Fund your secondary insurer on the date you cease to be actively employed.

Important:

- Participants must notify the Fund Office of the date that they ceased to be actively employed in writing no later than two weeks after said date, so that the Welfare Fund may properly coordinate their benefits with those of Medicare.

- Participants are reminded that they need to sign up for Medicare Benefits at the earliest time they are eligible in order to maximize the benefits contained within the section of the Retiree Benefits Booklet entitled "Benefits and Provisions for Pensioned Participants and their Eligible Dependents, Who are Entitled to Medicare".
    - Please note that the use of the word "entitled" is deliberate as the benefits of a non-actively contributing Participant aged 65 or older will only be entitled to the benefits outlined within the aforementioned Section.
- Participants that fail to notify the Fund Office or those who knowingly file their claims to the incorrect insurer will be subjected to the fraud provisions of the Welfare Fund.
- Participants who are entitled to receive Medicare Benefits are directed to read the provisions (outlined below) which can be found in the Retiree Benefits Booklet section entitled "Benefits and Provisions for Pensioned Participants and their Eligible Dependents Who are Entitled to Medicare."
    - Coordination of Benefits;
    - Eligibility;
    - Enrollment; and
    - Medicare.

Eligibility for Continued Coverage for the Eligible Dependents of a "Retired" Deceased Participant

As long as the participant had coverage at the time of death, coverage for Welfare Fund benefits will be extended to Covered Dependents for a period of 36 months from the date of death of the retired Participant. Coverage will be determined in the following manner for an eligible dependent child of a retired Participant who at the time of death had retiree benefits without Medicare benefits or retiree benefits with Medicare benefits:

- Upon attaining the age of 65 or becoming Medicare eligible, whichever is first, the benefits for the surviving spouse will be those that can be found in the Retiree Benefits Booklet in the section entitled "Benefits and Provisions for Pension Participants and their Eligible Dependents Who are Eligible for Medicare Benefits".
- Benefits for eligible Dependent Children of Retired Participants will be paid according to the provisions found in the Retiree Benefits Booklet in the section entitled "Benefits and Provisions for Pension Participants and their Eligible Dependents Who are Not Eligible for Medicare Benefits."

Interaction of COBRA and Retiree Benefits

If you are eligible for Retiree Medical coverage from the Fund, please be aware that, when you retire, you have the option of electing COBRA continuation of your active coverage instead of retiree medical coverage. If you do not elect COBRA continuation coverage when you retire within the timeframes described in the COBRA Election Notice, you will no longer have any rights to COBRA continuation coverage, even when you lose your retiree medical coverage.

However, if your spouse and/or dependent child(ren) who are covered under the retiree coverage experience a COBRA qualifying event while receiving retiree coverage (for example, if you die or get divorced), they will be entitled to continue the retiree coverage in accordance with COBRA for a period of up to 36 months from the date of the loss of retiree coverage.

ENROLLING FOR COVERAGE

How to Enroll

When you first become eligible to enroll for benefits, the Fund Office will notify you and send you an enrollment form. In order for you and your eligible dependents to be covered for benefits under this Plan, you must complete the enrollment form and return it to the Fund Office together with the documentation listed below in order for an eligible dependent to be covered.

Proof of Dependent Status

The following is the necessary proof of dependent status:

- **Spouse (Marriage):** A copy of the certified marriage certificate and Social Security card. Regardless of whether or not your spouse is employed, you must complete the Coordination of Benefits (COB) form. If no coverage is available, you must include a letter from your spouse's employer stating that there is no other health insurance available. If other coverage is available and your spouse is enrolled, the Fund Office must receive a copy of both sides of the insurance card.
- **Child (Birth):** A copy of the certified birth certificate and Social Security card.
- Adoption or Placement for Adoption: A copy of the certified court order signed by a judge, along with the birth certificate and Social Security card.
- **Stepchild:** A copy of the certified birth certificate identifying your spouse as the parent; a copy of the child's Social Security card; and a copy of the divorce decree (if applicable) between the biological parents to determine which parent is responsible for providing medical coverage and existence of other coverage from the biological parent (you must complete the Coordination of Benefits (COB) form).
- **Child Covered Pursuant to a Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document signed by a judge or a National Medical Support Notice.
- **Disabled Dependent Child:** A current written statement from the child's physician indicating: (1) the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically disabled; (2) that the child was so disabled prior to reaching age 19; and (3) an assertion that the child is incapable of self-sustaining employment as a result of that disability. You will also be required to provide proof that the child is dependent chiefly on you and/or your spouse for support and maintenance and is a qualified dependent for purposes of your federal tax return. Proof of the disabling condition as well as dependency must be submitted to the Fund Office prior to the child attaining age 26, when the child reaches the limiting age under the Plan.

- **Coverage for Parents of a Participant:** Certified copies of the birth certificate(s) and marriage certificate for the parent(s) and their Social Security cards and their Medicare ID cards (if applicable). In addition, each year the participant must submit a copy of the section of his or her tax return that confirms that his or her mother and/or father is listed as a dependent. The tax return must be submitted no later than May 1 of the calendar year in which it is due. Only single Participants who have never been married are eligible to enroll their dependent parent(s).
- Spouses and children of dependent children (grandchildren) are ***not*** covered under the Plan.

Special Enrollment

If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll your new dependent(s). You must complete an enrollment form and provide proof of dependent status within 60 days after the marriage, birth, adoption or placement of adoption. You should contact the Fund Office immediately after you are married, a child is born or a child becomes your legal responsibility or adoption proceedings have begun, to establish coverage.

If you decline enrollment (or do not enroll) a dependent because of other health insurance or group health plan coverage, you may be able to enroll your dependent in this Plan if you or your dependent loses eligibility for that other coverage (or if the employer stops contributing towards your dependent's other coverage). However, you must request enrollment within 60 days as described in this section after you or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage) and complete the enrollment forms and provide the required documentation.

State Children's Health Insurance Program

You and your dependents may also enroll in this Plan if you and/or your dependent(s) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you and/or your dependent(s) lose eligibility for that coverage or if you and/or your dependent(s) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends or are determined to be eligible for such assistance. To request an enrollment form or to obtain more information, contact the Fund Office.

Start of Coverage Following Enrollment

You must initially enroll for coverage within 60 days of becoming eligible for the health and welfare benefits provided for under the Plan.

If you have dependent(s) and enroll them when you are first eligible for coverage and it is within 60 days of your Initial Eligibility, their coverage will be effective retroactive to the date you are first eligible for benefits provided for under the Plan.

For newly added dependents, if the Fund Office receives a complete enrollment form and the necessary documentation within 60 days of the date of the marriage, birth, adoption, placement for adoption or loss of other group coverage or eligibility for or termination of Medicaid or CHIP, coverage will be effective:

- **For newborn child(ren):** Newborn child(ren) are covered for benefits retroactive to the date of birth.
- **For adopted dependent child(ren):** Adopted child(ren) are covered from the date that child is adopted or "placed for adoption" with you, whichever is earlier. A child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. A child who is placed for adoption with you within 31 days after the child was born will be covered from birth. However, if a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.
- **For a new spouse (and stepchildren, if applicable):** Your new spouse (and stepchildren) is covered for benefits retroactive to the date of marriage if you submit the proper paperwork within 60 days of the new marriage. If you submit paperwork after 60 days, coverage will begin the first day of the following month in which the paperwork is received.
- If you are enrolling because of loss of other coverage or loss of coverage through CHIP/Medicaid or because of eligibility for a premium assistance program through CHIP or Medicaid, coverage begins the first of the month following the date coverage terminates or eligibility begins for a premium assistance program.

Late Enrollment

If the Fund Office does not receive the necessary enrollment material for your dependents within 60 days of when you are first eligible for coverage or a special enrollment event, coverage will not become effective until the first day of the month following the month in which the Fund Office receives your completed enrollment form and the necessary documentation. If you do not properly enroll yourself and/or your dependents, claims for services rendered to you and/or them may be denied until the Fund Office receives the applicable enrollment material. In no event will any claims be paid that are beyond the Fund's claim filing deadline which is within 12-months of the date the claims are incurred.

Qualified Medical Child Support Order (Special Rule for Enrollment)

The Plan covers your dependent children for whom coverage has been court-ordered through a Qualified Medical Child Support Order (QMCSO). According to federal law, a QMCSO is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan.

If a court or state administrative agency has issued an order with respect to health care coverage for any child of a Participant, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the Participant, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the Participant is covered by the Plan, and advise them of the procedures to be followed to provide coverage for the child(ren).

Additional Information: For additional information (free of charge) regarding the procedures for administration of a QMCSO, please contact the Fund Office.

Decline Dental & Vision Benefits

There is no option to decline (opt out) of hospital, medical or prescription drug coverage provided by this Plan for you, the Participant. However, in accordance with Health Reform regulations, you do have the option to decline the Plan's Dental and/or Vision benefits. If you wish to decline either or both of these benefits, please send a notarized letter to the Fund Office with your request to opt out. You may opt out of Dental and/or Vision coverage at any time. Changes will be effective the first of the month following the month in which the Fund Office receives your request.

If you decline Dental and/or Vision benefits, you may re-enroll for such coverage at any time by contacting the Fund Office. Changes to your enrollment in either or both of these benefits will be effective the first of the month following the month in which you re-elect coverage.

Opt-Out of Coverage for Dependents

Dependents may not be enrolled for coverage unless you, the Participant, is also enrolled in the Plan. However, you may enroll yourself but pass up the opportunity to enroll your dependents and decline coverage for your dependents. You are only allowed to decline coverage for your dependent(s) if they are enrolled in other group coverage and provide proof of enrollment in that other coverage at the time you enroll for coverage.

If you have enrolled your dependents in coverage and later decide you wish to decline or opt-out of the Fund's coverage, you may do so by contacting the Fund Office. If, at a later date, you want the coverage you declined for your dependents, you may re-enroll at any time. Any changes will be effective the first of the month following the month in which the Fund Office receives the completed and signed form and any required proof.

Fraud & Abuse

Criminal penalties may be imposed against those who receive or attempt to receive health care plan benefits by committing fraud or abuse against the Plan. State fraud and abuse laws may also apply.

Any person who commits a fraudulent act against the Plan may be subject to a possible loss of benefits, as well as criminal prosecution, fine or imprisonment as provided by law. The following items may be considered fraud or abuse against the Plan, include but are not limited to:

1. Falsifying, withholding, omitting, or concealing information to obtain coverage.
2. Misrepresenting eligibility criteria for dependents (for example, marital status, age, or the right to claim a dependent for federal income tax purposes where required) to obtain or continue coverage for a person who would not otherwise meet the dependent eligibility criteria, as defined in the Plan, and qualify for coverage.
3. Withholding, omitting, concealing, or failing to disclose any medical history or health status where the person is required to calculate benefit payments.

4. Making or using any false writing or document in connection with obtaining coverage or payment for health benefits, including falsifying, or altering (a) a certificate of creditable coverage to reduce or eliminate waiting periods or pre-existing conditions or limitations under the Plan, (b) a claim form, or (c) medical records.
5. Permitting a person who is not covered under the Plan to use Plan identifying information to obtain covered services or payment under the Plan.
6. Making false or fraudulent representations in connection with delivery of, or payment for, health benefits, or being untruthful to obtain reimbursement under the Plan.
7. Obtaining, or attempting to obtain, medical care or covered services under the Plan by false or fraudulent pretenses.

Subject to the terms of the Affordable Care Act, the Fund reserves the right to terminate coverage for you and/or your Dependent(s) if you and/or your Dependent(s) are otherwise determined to be ineligible for coverage. Pursuant to the Affordable Care Act, the coverage will not be rescinded retroactively, except in certain permitted instances, such as if you or your covered Dependent(s) commit fraud or make an intentional misrepresentation (for example, in enrollment materials, a claim, or appeal for benefits or in response to a question from the Fund Administrator or its delegates). In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon 30 days' notice. Failure to inform the Fund Office that you or your Dependent is covered under another group health plan and knowingly providing false information to obtain coverage for an ineligible individual are examples of actions that constitute fraud or intentional misrepresentations. Coverage may also be eliminated retroactively (without notice) in cases in which it would not be considered rescission under the Affordable Care Act, such as failure to pay a required premium or contribution toward the cost of coverage. Examples of fraud against the Fund may also include your failure to notify the Fund Office of your divorce, your failure to inform the Fund Office that you have engaged in Disqualifying Employment, or your acceptance of payment from an Employer for hours of work that should have been reported to the Fund but were not, where you knew or should have known that the Employer would not report the hours. Where a Participant is found to have engaged in fraud, the Fund may suspend or permanently discontinue coverage for the Participant and his or her Dependents.

TERMINATION OF COVERAGE

When Your Coverage Ends

Your benefits terminate on the earliest of the following:

- on the last day of the last month of the Benefit Period when you fail to work and redeem the required number of hours during a Redemption Period for a Contributing Employer;
- 31 days after you enter active military service (see page 24 for more information on USERRA);
- the date the Plan terminates; or
- you start working in Non-Covered Employment as described below under "Immediate Cessation of Coverage".

Immediate Cessation of Coverage

- **Active Participants:** Your coverage, along with the coverage of your eligible dependents, will immediately cease upon the commencement of employment by you that is Non-Covered Employment. Non-Covered Employment is any employment with an employer who is not required to purchase stamps and contribute to this Plan in a category of employment that would otherwise be considered Covered Employment under the terms of this Plan.
- **Retired Participants with Coverage:** Your coverage, along with the coverage of your eligible dependents, will immediately be forfeited permanently upon the commencement of employment by you that is Non-Covered Employment which is any employment with an employer who is not required to purchase stamps and contribute to this Plan in a category of employment that would otherwise be considered Covered Employment under the terms of this Plan.

Under both circumstances, you are required to notify the Fund Office of such an event, and you and your eligible dependents may obtain COBRA continuation coverage following the loss of other coverage in accordance with the COBRA requirements described herein.

Rescission of Coverage

Your coverage may be terminated retroactively (rescinded) due to any of the following:

- in cases of fraud or intentional misrepresentation (you will be provided with 30 days advanced notice); or
- non-payment of premiums (including COBRA premiums). Failure to notify the Fund Office within 60 days of a divorce or of a child aging out of the Plan will be considered a non-payment of COBRA premiums. Coverage will be terminated retroactively to the date of the event, and you will be responsible for any claims paid from the date of the event.

The Plan will not rescind health coverage under the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or persons seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud or the individual makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan, and in other instances that may be prescribed in federal Treasury Regulations. For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance is attributable to a delay in administrative record keeping if the Participant does not pay any premiums for coverage after termination of benefits under the Plan.

A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contribution toward the cost of coverage (including COBRA premiums). A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the date of divorce.

Reinstating Your Coverage

If your benefits terminate, your eligibility will be reinstated on the first day of the month after the Benefit Period in which you once again meet the eligibility requirements.

When Coverage for your Eligible Dependents Ends

Coverage for your dependents ends when your coverage ends. In addition, coverage ends for your dependents earlier for the following events:

- Coverage ends for your spouse (and any stepchildren) when you and your spouse are legally divorced, and the divorce becomes final; or a court order is issued otherwise dissolving the marriage. When coverage ends for your spouse (and any stepchildren), your spouse (and any stepchildren) may elect to continue coverage under COBRA for up to 36 months in the event of divorce (see page 27 for details on COBRA Continuation Coverage). You or your spouse must notify the Fund Office within 60 days of your divorce (or the issuance of an order otherwise dissolving the marriage) so that claims are not improperly paid on behalf of your ex-spouse (and any stepchildren). At this time, you may also want to review your beneficiary designation for your death benefit. Once you are divorced (or the marriage is otherwise dissolved by court order), stepchildren from your former marriage are no longer eligible for coverage under the Plan but may be entitled to COBRA continuation coverage.
- The Fund Office requires you to submit supporting documentation such as a copy of your divorce decree (or other court order dissolving the marriage) and/or a copy of any Qualified Medical Child Support Order, if applicable. Contact the Fund Office if you have any questions.
- Coverage for your child(ren) ends:
    - The last day of the month in which he or she turns age 26; or
    - When he/she no longer meets the definition of a dependent.

Your child may elect COBRA continuation coverage for up to 36 months. The Fund Office tracks when a child reaches the limiting age and will notify you when coverage for your child ends. However, it is ultimately your responsibility to notify the Fund Office within 60 days of the date your child would otherwise lose coverage in order to protect his or her COBRA rights and ensure that you do not become financially responsible for claims paid on behalf of the child thereafter.

Also note that if your child is not capable of self-sustaining employment upon attaining age 26 because he or she is permanently and totally disabled and was so disabled prior to reaching age 19, you may continue coverage for that child for as long as your own coverage continues, and the child depends on you for more than one-half of his or her support. To qualify, your child's permanent and total disability must have begun before the child reached age 19. You must submit proof of the disability to the Plan Administrator within 60 days of the date your dependent child's coverage would otherwise end or within 60 days after your dependent child initially becomes eligible for benefits through the Plan. See the Enrollment section for procedures on how to continue coverage once it would otherwise end.

- Coverage for your dependent parent ends when the parent no longer qualifies as a dependent.

Please note that you will be responsible for reimbursing the Welfare Fund for any claims that are paid on behalf of your spouse, dependent child or dependent parent who is no longer an eligible dependent and continues to be covered by the Plan.

In the Event of Your Death

In the event of your (the Participant's) death, coverage for your spouse and/or dependent children will continue for 36 months at no cost to them provided that you were eligible for Plan benefits at the time of your death. Please note that this coverage runs concurrently with COBRA continuation coverage. Therefore, once the extension of benefits ends, your spouse and/or dependent children will not be eligible for any additional COBRA continuation coverage. However, if your child turns age 26 during the 36-month period, coverage will terminate under this extension and the child will be offered COBRA continuation coverage for the balance of the 36-months on a self-pay basis.

If You Divorce or Your Marriage is Dissolved by Court Order

If you and your spouse get a divorce or your marriage is otherwise dissolved by an order of a court of competent jurisdiction (i.e., void ab initio), your spouse will no longer be eligible for coverage under the Plan. If the Trustees pay benefits to your spouse that exceed the amount of benefits that should be paid under the terms of this Plan, the Trustees will have the right, to the greatest extent allowed by law, to recover the wrongfully paid benefits from you. Once your spouse is no longer eligible for coverage under the Plan, he or she may elect to continue coverage under COBRA for up to 36 months. You or your spouse must notify the Fund Office within 60 days of the date of the judgment of divorce or court order otherwise dissolving your marriage in order for your spouse to elect and receive COBRA continuation coverage. At that time, you may also want to review your beneficiary designation for your Death Benefit and AD&D benefits, if eligible.

LEAVE OF ABSENCE

The Welfare Fund complies with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). This legislation guarantees certain rights to individuals called to active duty in the armed forces of the United States. Your coverage under this Plan terminates 31 days after you enter active duty in the uniformed services. However, USERRA is a temporary continuation of your coverage when you are called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States. However, if you elect USERRA temporary continuation coverage, you (and any of your eligible dependents covered under the Plan on the day your leave starts) may continue Plan coverage on a self-pay basis for up to 24 months measured from the last day of the month in which you stopped working.

Duty to Notify the Plan and USERRA Coverage. In order to continue coverage under USERRA, you must notify the Fund Office, in writing and within 60 days (unless it is impossible or unreasonable to give such notice), that you have been called to active duty in the uniformed services and you provide a copy of that order. Once you have notified the Plan, you will be offered the right to elect USERRA coverage for yourself (and any of your eligible dependents covered under the Plan on the day your leave starts). The premium amounts (102% of the cost of average), election periods, and grace periods for USERRA Coverage are the same as COBRA Continuation Coverage. Additionally, you (and any of your eligible dependents covered under the Plan on the day your leave starts) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA continuation coverage and, therefore, either COBRA or USERRA continuation coverage can be elected, and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the election forms. Completed election forms must be submitted to the Fund Office in the same time frames as is permitted under COBRA continuation coverage.

In Lieu of Paying For USERRA. USERRA allows you to apply accumulated eligibility toward the cost of continuation coverage in lieu of paying for the USERRA continuation coverage. What this means is that you may maintain eligibility under the Plan and run out the balance of any Benefit Period(s) rather than pay for USERRA coverage. At the end of the Benefit Period when your accumulated eligibility is exhausted and coverage would otherwise end, you may pay for USERRA coverage under the self-pay rules of this Plan. If you do not want to use your accumulated eligibility to pay for USERRA coverage, you can choose to freeze your eligibility and instead proceed to pay for the USERRA coverage under the self-pay rules of this Plan.

After Discharge from the Armed Forces. When you are discharged from military service (not less than honorably), if you froze your eligibility, you will be reinstated on the day you return to work, provided you return to employment within: (i) 90 days from the date of discharge from the military if the period of service was more than 180 days; or (ii) 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or (iii) at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days. If you are hospitalized or convalescing from an injury caused by active duty, the time limits are extended up to 2 years. You must notify the Fund Office in writing within these time periods. Upon reinstatement, your coverage will not be subject to any exclusions or waiting periods other than

those that would have been imposed had the coverage not terminated. Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to the Fund Office. Questions regarding your entitlement to an approved leave of absence should be referred to your employer.

Coverage Under TRICARE

In addition to USERRA or COBRA coverage, your eligible dependents may be eligible for health care coverage under TRICARE (the U.S. Department of Defense's health care program for uniformed service members and their families). This Plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice for you and your eligible dependents.

If You Take Family and/or Medical Leave

Under the Family and Medical Leave Act of 1993 (FMLA), as amended, eligibility for benefits must be extended to active participants and their dependents if the active participant is eligible for and has been granted leave by his or her employer pursuant to FMLA, and if the participant's employer makes the required contributions to the Fund. If you are taking FMLA leave that has been approved by your employer, your employer is responsible for making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility.

Maintenance of Plan Benefits. During your leave, you will continue to receive medical coverage through the Fund if you properly notify your employer of your leave and your employer continues to make contributions to the Fund on your behalf.

The Fund will maintain your prior eligibility until the end of the leave, provided your employer properly grants the leave under the FMLA law and makes the required notification and payment to the Fund. If your employer does not make contributions for coverage during the FMLA leave, the Fund will not absorb the cost of the coverage during such leave. You are required to notify the Fund Office when you are taking FMLA leave. To find out more about FMLA and the terms under which you may be entitled to it, contact your employer.

Paid Family Leave

New York State's Paid Family Leave law (PFL) provides eligible Participants of the Fund who are employed by Contributing Employers with paid leave to:

1. bond with a newborn, newly adopted or new foster child;
2. take care of a family member with a serious medical condition; or
3. address circumstances arising from a family member's call to active duty with the military.

A participant employed by one or more Contributing Employers whose regular work schedule is 20 or more hours per week becomes eligible for New York State's paid family leave after being employed with one or more Contributing Employers for 26 consecutive weeks.

MAXIMUM LEAVE	MAXIMUM BENEFIT
12 Weeks	67% of employee's average weekly wage or 67% of state's average weekly wage, whichever is lower.

The Fund will maintain your prior eligibility until the end of the PFL, provided your employer properly grants the leave under state law and makes the required notification and payment to the Fund. If your employer does not make contributions for coverage during the PFL, the Fund will not absorb the cost of the coverage during such leave. You are required to notify the Fund Office when you are taking a PFL. To find out more about PFL and the terms under which you may be entitled to it, contact your employer.

CONTINUATION OF COVERAGE (COBRA)

Introduction

COBRA continuation coverage is a temporary extension of coverage under the Plan. This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. Please note, if you receive COBRA continuation coverage, you will not be eligible for the death benefit otherwise provided by the Plan.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review this section or contact the Fund Office.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

COBRA continuation coverage is the same health coverage that the Plan gives to other participants or beneficiaries who are not getting continuation coverage. COBRA continuation coverage is not available for Weekly Loss of Time, Accidental Dismemberment or Death benefits. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

A child who becomes a dependent child by birth, adoption, or placement for adoption with the covered Participant or retiree during a period of COBRA continuation coverage is also a qualified beneficiary. However, a person who becomes the new spouse of a Participant or retiree during a period of COBRA continuation coverage is not a qualified beneficiary.

Qualifying Event. Qualifying events are those shown in the subsequent chart. Qualified beneficiaries are entitled to COBRA continuation coverage when qualifying events (which are specified in the law) occur, and as a result of the qualifying event, coverage of that qualified beneficiary ends. A qualifying event triggers the opportunity to elect COBRA when the covered individual loses health care coverage under the Plan. If a covered individual has a qualifying event but does not lose health care coverage under the Plan (for example, the employee continues working even though entitled to Medicare), then COBRA will not be offered until such time the individual loses coverage due to the qualifying event.

Maximum Period of COBRA Continuation Coverage. The maximum period of COBRA continuation coverage is generally 18 months or 36 months, depending on which qualifying event occurs. The period of COBRA continuation coverage is measured from the time the qualifying event occurs. The 18-month period of COBRA continuation coverage may be extended for up to 11 months under certain circumstances (described in another section of this chapter on extending COBRA in cases of disability). That period may also be cut short for the reasons set forth in "Termination of COBRA," which appears later in this section.

Qualifying Events and Maximum Periods of Continuation of Coverage

QUALIFYING EVENT	EMPLOYEE	SPOUSE	DEPENDENT CHILD(REN)
Employee terminated (for reason other than gross misconduct)	18 Months	18 Months	18 Months
Employee reduction in hours worked (making employee ineligible for the same coverage)	18 Months	18 Months	18 Months
Employee dies	n/a	36 Months	36 Months
Employee becomes divorced (only applies to spouse and stepchildren)	n/a	36 Months	36 Months
Employee becomes entitled to Medicare (only applies if there is a loss of coverage)	n/a	36 Months	36 Months
Dependent child ceases to have dependent status	n/a	n/a	36 Months

Each qualified beneficiary, with respect to a particular qualifying event, has an independent right to elect COBRA continuation of coverage. For example, both you and your spouse may elect continuation of coverage, or only one of them. A parent or legal guardian may elect continuation coverage for a minor child.

Notice You Must Give the Welfare Fund

As a covered Participant or qualified beneficiary, you must provide the Welfare Fund with timely notice of certain qualifying events. Those qualifying events include the following:

- The divorce of a covered Participant from his or her spouse.
- A beneficiary ceasing to be covered under the Plan as a dependent child of a Participant.

- The occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. (This second qualifying event could include an employee's death, divorce or child losing dependent status.)

In addition to these qualifying events, there are two other situations where a covered employee or qualified beneficiary is responsible for providing the Welfare Fund with notice within the time frame noted in this section:

- A qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If this determination is made at any time during the first 60 days of COBRA coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18 months maximum Benefit Period, for a total of 29 months of COBRA coverage.
- The Social Security Administration determines that a qualified beneficiary is no longer disabled.

You must make sure that the Welfare Fund is notified of any of the occurrences listed above. Failure to provide this notice in the form and within the time frames described below may prevent you and/or your dependents from obtaining or extending COBRA coverage.

How a notice should be provided. Notice of any of the five situations listed above must be provided in writing. You may send a letter to the Welfare Fund containing the following information: your name, which of the five events listed above you are providing notice of, the date of the event, and the date on which the participant and/or beneficiary will lose coverage.

When a notice should be sent. If you are providing notice due to a divorce (or court order otherwise dissolving your marriage) or a dependent losing eligibility for coverage or a second qualifying event, you must send the notice no later than 60 days after (1) the date upon which coverage would be lost under the Plan as a result of the qualifying event, (2) the date of the qualifying event, or (3) the date on which the qualified beneficiary is informed through the furnishing of a summary plan description or initial COBRA notice of the responsibility to provide the notice and the procedures for providing this notice to the Welfare Fund.

If you are providing notice of a Social Security Administration determination that you are no longer disabled, notice must be sent no later than 60 days after the letter of the date of the determination by the Social Security Administration that you are no longer disabled.

Who can provide a notice. The covered Participant, qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered Participant or qualified beneficiary, may provide notice. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if a covered Participant, his/her spouse, and his/her child are all covered by the Plan, and the child ceases to become a dependent under the Plan, a single notice sent by the spouse would satisfy this requirement.

In the event of the covered Participant's death, the Participant's family should notify the Welfare Fund promptly and in writing if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in the transmittal of information to the Welfare Fund.

Notice when you become entitled to COBRA Continuation Coverage. When your health care coverage ends—because your employment terminates, your hours are reduced so that you are no longer entitled to coverage under the Plan, you die, become entitled to Medicare (if this results in a loss of coverage), or when the Welfare Fund is notified that a dependent child lost dependent status or you are divorced—the Welfare Fund will give you, your spouse and/or your covered dependents notice of the date on which your coverage ends, as well as the information and forms needed to elect COBRA continuation coverage. Under the law, you and/or your covered dependents will then have only 60 days from the date of receipt of that notice, to enable you and/or them to apply for COBRA continuation coverage.

If you and/or any of your covered dependents do not choose COBRA continuation coverage within 60 days after receiving notice, you and/or they will have no group health coverage from the Plan after the date coverage ends.

Where you or your dependents have provided notice to the Welfare Fund of a divorce (or court order otherwise dissolving a marriage), a beneficiary ceasing to be covered under the Plan as a dependent, or a second qualifying event but are not entitled to COBRA, the Welfare Fund will send you a written notice stating the reason why you are not eligible for COBRA continuation coverage.

Coverage that will be provided if you elect COBRA Continuation Coverage. If you and/or your dependent(s) choose COBRA continuation coverage, the Plan is required to provide coverage that is identical to the current coverage for medical, vision and dental benefits that is provided for similarly situated employees or family members. Your coverage will depend on whether you chose and enroll in Core or Non-Core COBRA continuation coverage.

Please note that COBRA continuation coverage does not include the following benefits: Weekly Loss of Time, Accidental Dismemberment and Death.

The same rules about dependent status and qualifying changes in family status that apply to active Participants will apply to you and/or your dependent(s). If, during the period of COBRA continuation coverage, the Plan's benefits change for active Participants, the same changes will apply to you and/or your dependent(s).

When the Maximum Period of Continuation Coverage May be Extended

Second qualifying event. If your COBRA continuation coverage (according to the table) is for a maximum period of 18 months, and during that period, another qualifying event takes place that would otherwise entitle a spouse or dependent child to a 36-month period of continuation coverage, the 18-month period will be extended for that spouse or dependent child. The total period of coverage for any spouse or dependent child will never exceed 36 months from the date of the first qualifying event.

For example, if you terminated employment and elected COBRA continuation coverage for 18 months for yourself and your covered spouse and/or dependent child(ren), and you died during that 18-month period, the continuation coverage for your spouse and/or dependent child(ren) could be extended for the balance of 36 months from the date your employment terminated.

Entitlement to Social Security Disability Income Benefits. If you, your spouse or any of your covered dependent children are entitled to COBRA continuation coverage for an 18-month period, that period can be extended for the covered person who is determined to be entitled to Social Security disability income benefits, and for any other covered family member, for up to 11 additional months if:

- The disability occurred on or before the start of COBRA continuation coverage, or within the first 60 days of COBRA continuation coverage;
- The disabled covered person receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration within the 18-month COBRA continuation period; and
- You or the disabled person notifies the Welfare Fund of such a determination within that 18-month period.

This extended period of COBRA continuation coverage will end at the earlier of the end of 29 months from the date of the qualifying event or the date the disabled individual becomes entitled to Medicare.

The extended period of COBRA continuation coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of COBRA continuation coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the Participant) during the 18-month period of COBRA continuation coverage.

In no case is an employee whose employment has been terminated or had a reduction in hours entitled to COBRA continuation coverage for more than a total of 18 months (unless the employee is entitled to an additional period of up to 11 months of COBRA continuation coverage on account of disability as described in the above section). As a result, if an employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

In no case is anyone else entitled to COBRA continuation coverage for more than a total of 36 months.

What you must pay for COBRA Continuation Coverage. You, your covered spouse and/or your covered dependent child(ren) will have to pay the full cost of the coverage during the COBRA continuation period. Any person who elects COBRA continuation coverage must pay the full cost of the COBRA continuation coverage. The Fund is permitted to charge the full cost of coverage based on a composition rate for similarly situated active Participants, plus an additional 2%. If the 18-month period of COBRA continuation coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for COBRA continuation coverage that is in effect at the time he or she becomes entitled to it. The cost of COBRA continuation coverage may be subject to future increases during the period it remains in effect.

> **Note: You will not receive an invoice (bill) for the initial COBRA premium payment or for the monthly COBRA premium payments. You are responsible for making timely payments for COBRA continuation coverage. If you fail to timely pay your COBRA premium payments as explained hereafter, your coverage and that of your eligible dependents will terminate.**

Grace Periods. The amount you, your covered spouse and/or your covered dependent child(ren) must pay for your COBRA continuation coverage will be payable monthly. There will be an initial grace period of 45 days to pay the first amount due, starting with the date COBRA continuation coverage was elected. Thereafter, monthly premium payments are due on the first of every month. Participants that are having difficulty making payment on time will be allowed a 30-day grace period beginning from the day payment should have been received. However, if payment of the amounts due is not received by the end of the applicable grace period, the COBRA continuation coverage will terminate.

If the Fund Office does not receive your COBRA payment by the due date (the first of the month), your COBRA coverage will be cancelled on the first day of the month. However, if your COBRA premium is paid within the 30-day grace period, coverage will be reinstated back to the first day of that COBRA Benefit Period. Payment is considered made when it is postmarked.

Enrolling in Medicare instead of COBRA Continuation Coverage

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA continuation coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA continuation coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit www.medicare.gov/medicare-and-you.

Termination of COBRA Continuation Coverage. COBRA continuation coverage may be terminated if:

- medical or dental coverage is no longer provided to any similar employees or participants;
- you do not pay the applicable premium for your COBRA continuation coverage on time;
- the covered person enrolls in Medicare after the COBRA election; or
- the covered person is or becomes covered under another group health plan after the COBRA election.

If any covered person enrolls in Medicare, the COBRA continuation coverage of that person ends, but the COBRA continuation coverage of any covered spouse or dependent child of that covered person will not be affected.

If continuation coverage is terminated before the end of the maximum Benefit Period, the Welfare Fund will send you a written notice as soon as possible following the determination that continuation coverage will terminate. The notice will set out why COBRA continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

Other Information about COBRA Continuation Coverage. If the coverage provided by the Plan is changed in any respect for active Participants, those changes will apply at the same time and in the same manner for everyone whose coverage is continued as required by COBRA. If any of those changes result in either an increase or decrease in the cost of coverage, that increase, or decrease will apply to all individuals whose coverage is continued as required by COBRA as of the effective date of those changes.

Other Coverage Options Besides COBRA Continuation Coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions. Questions concerning this Plan, or your COBRA continuation coverage rights should be addressed to the Fund Office. For more information about your rights under the Employee Retirement Income Security Act, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keeping the Welfare Fund Informed of Address Changes.

To protect your family's rights, let the Fund Office know about any changes in the addresses of family members. Send the information to:

I.U.O.E. Local 15 Welfare Fund
44-40 11th Street
Long Island City, New York 11101

You should keep a copy, for your records, of any notices you send to the Fund Office. The Fund Office is the COBRA administrator.

MEDICAL COVERAGE

How the Plan's Medical Program Works

You are covered for expenses you incur for most, but not all, medical services and supplies as described in this SPD. Covered services are eligible medical expenses that are determined by the applicable Claims Administrator, and are limited to those that are:

- "Medically Necessary," but only to the extent that the charges are "Allowed Charges" (as those terms are defined in the "Definitions" section of this SPD);
- For the diagnosis or treatment of an injury or illness;
- Not services or supplies that are excluded from coverage (which are listed in the "Exclusions and Limitations" section of this SPD); and
- Not services or supplies in excess of a maximum Plan benefit (as shown in the "Schedule of Medical Benefits" section of this SPD).

Generally, the Plan will not reimburse you for any expenses that are not considered covered services. ***This means you are responsible for paying the full cost of all expenses that are:***

- Not determined to be Medically Necessary;
- Determined to be in excess of the Maximum Allowed Amount (see definition of "Maximum Allowed Amount");
- Not covered by the Plan;
- In excess of a maximum Plan benefit; or
- Payable on account of a penalty due to failure to comply with the Plan's Utilization Management Requirements, as described later in this SPD.

Participating (In-Network) Provider PPO and Non-Participating (Out-of-Network) Benefits

The Plan's Network is the Anthem PPO. You may choose to use any provider you want. However, if you receive medical services or supplies that are considered In-Network or Participating Providers (as described below), you will be responsible for paying less money out of your pocket. Out-of-Network benefits are also provided by the Anthem PPO Network but may cost you more money out of your pocket.

The Schedule of Medical Benefits lists how much the Plan pays and how much you pay for each type of health care service. Your cost-sharing portion includes "deductibles" "copayment" and/or "coinsurance" as described below. For Participating Providers, once you reach your annual maximum out-of-pocket limit, the Plan will begin to pay 100% of the Maximum Allowed Amount for the rest of the calendar year. Be aware that there is no out-of-pocket limit for Non-Participating Providers so you will be responsible for any cost-sharing for the entire year.

Participating (In-Network) Provider Anthem PPO

If you receive medical services or supplies from a health care provider that is contracted with the Plan's network you will be responsible for paying less money out of your pocket. This is because health care providers, hospitals and other facilities who are under a contract with the network have agreed to accept the discounted amount the Plan pays for covered services (plus any applicable copayment (or other cost-sharing) the covered individual is responsible for paying), as payment in full. See Schedule of Medical Benefits for a description of cost-sharing.

While you may choose any provider you wish and do not have to utilize Participating Providers, you should always consider receiving health care services first through the Participating Providers/In-Network Benefits portion of this Plan. When you use a network provider, you save money for yourself and the Plan because the network provider has agreed to charge a discounted dollar amount and to accept that amount (plus any copayment as payment in full). This means that the provider is not allowed to "balance bill" you any amounts in addition to any applicable copayment. If you have questions or need a listing of physicians and hospitals that participate in the PPO Network (provided free of charge), see page 2 for PPO contact information.

Out-of-Pocket Maximum for Participating Providers/In-Network Services. This Plan has an Out-of-Pocket Maximum for In-Network benefits which limits your annual cost-sharing for covered essential health benefits received from Participating Providers related to Medical and Prescription Drug Programs to the amounts permitted under the Affordable Care Act and implementing regulations. The Out-of-Pocket Maximum is the most you pay during the calendar year before this Plan starts to pay 100% for covered essential health benefits received from Participating Providers. Covered expenses are applied to the Out-of-Pocket Maximum in the order in which eligible claims are processed by the Plan. The amount of the Out-of-Pocket Maximum may be adjusted annually, in an amount as published by the Department of Health and Human Services.

The out-of-pocket limit for Medical benefits is $1,000 per individual and $2,000 for a family (which includes 2 or more covered family members). Your payments for covered In-Network medical services, such as copayments, will count towards the calendar year out-of-pocket maximum. In addition, copayments for using Out-of-Network Emergency Services will count towards the In-Network Out-of-Pocket Maximum.

Expenses that do not count towards the In-Network Out-of-Pocket Maximum include prescription drug, vision and dental expenses, excluded services, penalties for not obtaining pre-certification, and expenses arising from the use of an Out-of-Network provider. There is a separate Out-of-Pocket Maximum for prescription drugs. Please refer to the Prescription Drug section for details.

There is no Out-of-Pocket Maximum for Non-Participating Providers, and these expenses may not be used to meet the In-Network Out-of-Pocket Maximum.

Anthem PPO Network

Where To Find Network Providers. Anthem's network gives you access to providers within the Plan's operating area of 28 eastern New York State counties. To locate a provider in Anthem's operating area, visit www.anthembluecross.com. You can search for providers by name, address, language spoken, specialty and hospital affiliation. The search results include a map and directions to the provider's office. Call 800-810-BLUE (2583) or visit www.bcbs.com to locate participating BlueCard PPO® providers.

How To Access Primary and Specialty Care Services. To access primary care services, simply visit any network physician who is a general or family practitioner, internist, or pediatrician. The Plan covers care provided by any network specialty care provider you choose. Referrals are never needed to visit any network specialty care provider.

Continuity of Coverage

If you are a continuing care patient, and the Plan terminates its contract with your in-network provider or facility, or your benefits under a group health are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, the Plan will do the following:

- Notify you in a timely manner of the Plan's termination of its contracts with the in-network provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and
- Allow you 90 days of continued coverage at in-network cost sharing to allow for a transition of care to an in-network provider.

Non-Participating (Out-of-Network) Providers

The Out-of-Network Benefits portion of this Plan covers health care services described in the Schedule of Medical Benefits section of this SPD when you choose to receive the covered services from Non-Participating Providers. Non-Participating Providers are those who are not contracted with the Anthem PPO and who do not generally offer any fee discount to the participant or to the Plan. When you use a Non-Participating provider, you will be responsible for meeting an annual Deductible. Once you meet the deductible, benefits are generally subject to a coinsurance amount and any balances over the Maximum Allowed Amount which will be your sole financial responsibility.

The annual Deductible is the amount you must pay each calendar year, toward eligible medical expenses, before the Plan begins to pay benefits. Once you satisfy the annual Deductible, the Plan will begin to pay benefits. The Plan maintains an individual Deductible which is the maximum amount each covered person has to pay toward eligible medical expenses before Plan benefits begin for that covered person. The Plan's individual Deductible is $250 per individual for Out-of-Network benefits. Coinsurance refers to how you and the Plan will split the cost of certain covered medical expenses. Once you have met your annual Deductible, the Plan generally pays a percentage (generally 80%) of the Allowed Amount, and you (and not the Plan) are responsible for paying the rest including any balance billing as described below. The part you pay is called the Coinsurance. The coinsurance related to a covered benefit is described on the Schedule of Medical Benefits.

Non-Participating Providers may bill a Plan participant a non-discounted amount for any balance that may be due in addition to the Maximum Allowed Amount payable by the Plan, also called "balance billing". Balance billing occurs when a healthcare provider bills a patient for charges (other than the deductible) that exceed the Plan's payment for a covered service. See the next section for information on how the Plan calculates the Maximum Allowable Amount. To avoid balance billing, you should consider using Participating Providers since you will solely be responsible for paying any balance billing charged by your Non-Participating provider.

Maximum Allowed Amount

The Reimbursement for services rendered by Participating and Non-Participating Providers, is based on the Maximum Allowed Amount for the Covered Service that you receive. The Maximum Allowed Amount is the maximum amount of reimbursement the Plan will pay for services and supplies:

- that meet our definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary;
- that do not exceed the Plan's Fee Schedule or negotiated amount; and
- that are provided in accordance with all applicable Precertification, Medical Management Programs or other requirements set forth in this SPD.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met the Deductible. When you receive Covered Services, the Plan will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and determine, among other things, the appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the determination of the Maximum Allowed Amount. Application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Plan has determined that the claim submitted was inconsistent with procedure coding rules and/or our reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code. Likewise, when multiple procedures are performed on the same day by the same Provider or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures. The Maximum Allowed Amount varies depending upon whether the Provider is a Participating Provider or a Non-Participating Provider as described below.

- **Maximum Allowed Amount for Participating Providers.** For Covered Services performed by a Participating Provider, the Maximum Allowed Amount is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay a Copayment or other applicable cost-sharing. Please call Customer Service for help in finding a Participating Provider or visit www.anthembluecross.com.

- **Maximum Allowed Amount for Non-Participating Providers.** Providers who have not signed any contract with Anthem and are not in any of Anthem's networks are considered Non-Participating (or Out-of-Network) Providers. If you use a Non-Participating Provider, the Maximum Allowed Amount may not be accepted as payment in full for Covered Services and you may be balance billed.

Pre-certification and Medical Management

Managing your health includes getting the information you need to make informed decisions and making sure you get the maximum benefits the Plan will pay. To help you manage your health, the Plan requires that you obtain Pre-certification for certain services and supplies. Anthem provides the review for all In-and Out-of-Network/Participating Providers benefits under its Medical Management Program. This Program is a service that pre-certifies participating hospital admissions and certain treatments and procedures, to help ensure that you receive the highest quality of care for the right length of time, in the right setting and with the maximum available coverage.

Anthem's Medical Management Program for In-Network Benefits

Anthem's Medical Management Program works with you and your provider to help confirm the medical necessity of services and help you make sound health care decisions. The program helps ensure that you and your family members receive the highest quality of care at the right time, in the most appropriate setting. You can contact Anthem's Medical Management program by calling the Participant Services telephone number located on your identification card. Anthem may, from time to time, waive, enhance, modify, or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services. In addition, they may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. They may also exempt your claim from medical review if certain conditions apply. Just because Anthem exempts a process, provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future or will do so in the future for any other Provider, claim or Participant. Anthem may stop or modify any such exemption with or without advance notice. You may determine whether a Provider is participating in certain programs by checking Anthem's on-line Provider Directory or by contacting customer service at the telephone number that is on your ID card.

Pre-certification Requirement/Penalty. Your Provider should call Anthem between the hours of 8:30 a.m. to 5:00 p.m., Monday through Friday for assistance. Your Provider will generally call to seek precertification for In-Network claims, but it is ultimately your responsibility to make sure that the doctor, hospital, facility, or other service provider has contacted Anthem PPO to ensure that the care, treatment, or supply is pre-certified before you receive it. If the call to pre-certify the services is made as needed, you will receive maximum benefits. Otherwise, your benefits may be denied or reduced by 50%, for each admission, treatment, or procedure. This benefit reduction also applies to certain same-day surgery and professional services rendered during an inpatient admission. If the admission or procedure is not Medically Necessary, no benefits will be paid.

Pre-certification for Non-Participating/Out-of-Network Benefits

You must obtain prior approval in order for the Plan to make payments for certain Out-of-Network services or supplies. All requests for precertification must be made by a physician as directed and be received prior to the time treatment is rendered. Failure to obtain pre-certification will result in denial of the claim.

Diagnostic Testing Warning: Diagnostic tests performed within a hospital setting for reasons that do not involve an emergency or one of the other exceptions listed under diagnostic testing provision of the Plan, will be paid as an Out-of-Network claim and you (the patient) will be responsible for any balance billed charges. This includes those facilities that are billed under the tax-identification number of a hospital. To avoid any balance billing, you should utilize a participating freestanding diagnostic facility whenever you require routine diagnostic tests.

You should know that more and more physicians are leasing diagnostic equipment from hospitals. Although the diagnostic services were performed in a physician's office, the leasing arrangement allows for your claims to be billed by the owner of the equipment (the hospital) which then allows your diagnostic claims to be billed at a much higher rate. You can avoid most out of pocket costs if you:

- Inform your physician that, unless there is "medical necessity, you must have your diagnostic testing performed in a participating facility that is non-hospital related in order to avoid having to pay higher out-of-pocket costs.
- Become familiar with the in-network freestanding diagnostic testing facilities available in your geographical area along with the days and times of their operation.

Services that Require Pre-certification

To help ensure that you receive the maximum coverage available, you are required to obtain Prior Authorization or Pre-certification for the following services and supplies either **with Anthem's Medical Management Program (for In-Network services) or the Fund Office (for Out-of-Network services):**

You Or Your Doctor Must Call To Pre-Certify:	Where To Call: Participating/In-Network Provider	Where To Call: Non-Participating/ Out-Of-Network Provider
All Hospital Admissions At least 2 weeks prior to any planned surgery or Hospital admission Within 48 hours of an emergency Hospital admission, or as soon as reasonably possible Before you are admitted to an Inpatient Rehabilitation Facility for physical therapy/rehabilitation and Mental Health and Substance Use Disorder treatment only Before you are admitted to a Skilled Nursing Facility Before you are admitted to an Inpatient Residential Facility for Mental Health or Substance Use Disorder (residential facilities are only covered in these circumstances)	Anthem Blue Cross Blue Shield	Not Applicable Benefits are not covered for Non-Participating Providers
Maternity Care Notification is not required but please provide notification within the first three months of pregnancy if possible. Within 48 hours after the actual delivery date, if stay is expected to extend beyond the minimum length of stay for mother and newborn inpatient admission: forty-eight (48) hours for a vaginal birth; or ninety-six (96) hours for cesarean birth	Anthem Blue Cross Blue Shield	Not Applicable Benefits are not covered for Non-Participating Facilities
Before You Receive/Use Home health care Hospice Care Outpatient/ambulatory surgical treatments including but not limited to: Bariatric /gastric bypass LASIK surgery (eyes) Nasal Surgery Reconstructive and corrective surgery Podiatric surgery Any dental work performed in a facility setting	Anthem Blue Cross Blue Shield	Benefits are not covered for Non-Participating Facilities.

You Or Your Doctor Must Call To Pre-Certify:	Where To Call: Participating/In-Network Provider	Where To Call: Non-Participating/ Out-Of-Network Provider
Partial Hospital Programs (PHP) **Intensive outpatient programs (IOP)**	Anthem Blue Cross Blue Shield	Benefits are not covered for Non-Participating Facilities
Diagnostics (certain procedures including high tech imaging like MRIs and CAT scans)	Anthem Blue Cross Blue Shield	Up to the Allowed Amount, contact Anthem Blue Cross Blue Shield
Outpatient Occupational, physical, speech and vision therapy Cardiac and Pulmonary Rehabilitation Durable medical equipment, orthotics, and prosthetics (including wigs) Air ambulance	Anthem Blue Cross Blue Shield	Anthem Blue Cross Blue Shield

You must also request Pre-certification for the following services:

- More than three sonograms related to a maternity
- Neuropsychological testing
- Treatments related to Orthotropy
- Private duty nursing
- Sclerotherapy
- Sleep studies
- Vein therapy

Other services may be subject to retrospective review by the Anthem Medical Management team for Participating/Non-Participating Providers to determine medical necessity.

Case Management Provided by Anthem Blue Cross Blue Shield

If you need additional support for a serious illness, Anthem's Medical Management Program's Case Management staff can provide assistance, and support when you or a member of your family faces a chronic or catastrophic illness or injury. The program's nurses can help you and your family find appropriate, cost-effective health care options, reduce medical costs, and assure quality medical care. A Case Manager serves as a single source for the patient, provider, and Anthem, assuring that the treatment, level of care, and facilities are appropriate for your needs. For example, Case Management can help with cases such as:

- Cancer
- AIDS
- Hemophilia
- Stroke
- Chronic illness
- Spinal cord and other traumatic injuries

Assistance from Case Management is evaluated and provided on a case-by-case basis. In some situations, the Medical Management Program staff will initiate a review of a patient's health status and the attending doctor's plan of care. They may determine that a level of care is not necessarily desirable, appropriate, or cost-effective. If you would like Case Management assistance following an illness or surgery, contact the Medical Management Program.

Important Notices

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. See the Utilization Management section of this SPD for information on precertification.

Women's Health and Cancer Rights Act

This Plan complies with the Women's Health and Cancer Rights Act that indicates that for any Covered Person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:

- Reconstruction of the breast on which the mastectomy was performed.

- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and the treatment of physical complications at all stages of the mastectomy, including lymphodemas.

Benefits for these services shall be subject to the same Deductible, Copayments and/or Coinsurance as for other services covered under this Plan.

Patient Protection Rights

The Fund allows (but does not require) the designation of a primary care provider (PCP). You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Anthem Blue Cross. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Fund or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Fund's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who are considered PCPs, pediatricians or specialize in obstetrics or gynecology, contact Anthem Blue Cross.

As noted above, the Fund does not require the selection or designation of a primary care provider. You have the ability to visit any Participating or Non-Participating Provider; however, payment by the Plan may be less for the use of a Non-Participating Provider and you may be balance billed for any amounts above the Maximum Allowed Amount payable by the Plan. ***You are solely responsible for the payment of any balance billed amount.***

Provider Nondiscrimination

In accordance with Section 2706 of the Public Health Service Act, as amended by the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by Anthem Blue Cross Blue Shield. Anthem is permitted to establish varying reimbursement rates based on quality or performance measures.

Routine Patient Costs in Connection with Approved Clinical Trials

The Plan pays for charges incurred due to participation in either a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, provided the charges are those that are:

- ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Plan if the individual were not participating in the Approved Clinical Trial; and

- not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the Provider of the Approved Clinical Trial.

A Participant or dependent is eligible for payment of charges related to participation in an Approved Clinical Trial if they:

- satisfies the protocol prescribed by the Approved Clinical Trial provider; and
- either:
    - the individual's network participating provider determines that the individual's participation in the Approved Clinical Trial would be medically appropriate; or
    - the individual provides the Plan with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

For the purposes of this provision, an Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Approved Clinical Trial's study or investigation must be:

- approved or funded by one or more of:
    - the National Institutes of Health NIH);
    - the Centers for Disease Control and Prevention (CDC);
    - the Agency for Health Care Research and Quality (AHCRQ);
    - the Centers for Medicare and Medicaid Services (CMS);
    - a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA);
    - a qualified non-governmental research entity identified by NIH guidelines for grants; or
    - the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or a drug trial that is exempt from investigational new drug application requirements.

Excluded Expenses include:

- Expenses incurred due to participation in an Approved Clinical Trial that are: (1) the investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial; (2) items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

- Expenses incurred at a non-network provider if a network participating provider will accept the patient in an Approved Clinical Trial.
- Expenses incurred at a non-network provider, unless the Approved Clinical Trial is only offered outside the patient's state of residence.

If one or more of the Plan's participating providers is participating in a clinical trial, the Plan may require that you participate in the trial through such a participating provider if the provider will accept you as a participant in the trial. The Plan is only required to cover Approved Clinical trials on a non-network basis if the Approved Clinical trial is offered outside the patient's state of residence.

A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Schedule of Medical Benefits

The Plan provides a broad range of benefits to you and your family. Following is a brief overview of your coverage. Some services require precertification. Refer to the prior section of this SPD for information about the Medical Management Program and a list of the services that require pre-certification.

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
Annual Deductible	$0 (None)	$250
Out-of-Pocket Maximum	$1,000/individual	Out-of-Pocket Maximum
PROVIDER/PROFESSIONAL SERVICES		
Home Office Visits Primary Care Provider (PCP) visits Mental Health and Substance Use Disorders visits	$15 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Specialist Visits	$30 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
SwiftMD Program Telemedicine Program (see page 66 for a detailed description)	$0 Copayment	N/A

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
Acupuncture Up to 16 visits per calendar year Only one service payable per day Paid for treatment of medical diagnosis only Visit maximums do not apply to treatment provided in conjunction with a Mental Health or Substance Use Disorder diagnosis	$30 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Allergy Care Office Visit Testing Treatment	$30 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Anesthesia Payable in connection with a surgery when anesthesia is administered by a doctor other than the operating surgeon his/her assistant or an employee of the hospital	$0 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Chiropractic Care Up to 24 visits and four chiropractic x-rays per calendar year per person) Visit maximums do not apply to treatment provided in conjunction with a Mental Health or Substance Use Disorder diagnosis	$15 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Diabetes Management See *Diabetes Management* subsection in the Wellness Program section for details	$0 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
DIAGNOSTIC PROCEDURES IN FREE-STANDING FACILITY (Certain procedures require Precertification)		
X-rays, laboratory tests, and other radiological imaging	$0 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Radium and Radionuclide therapy	$0 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Nuclear cardiology services	$0 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Laboratory Tests	$0 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
MRIs/MRAs, PET/CAT scans and other scans (Precertification required In-Network)	$40 copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Services associated with Genetic Testing Genetic counseling is not covered for Non-Participating Providers and only covered for Participating Provider when required under ACA Preventive benefits (and is covered with no copayment in such cases)	Applicable Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Tilt table testing and pulmonary function testing (whether performed in a free-standing facility or hospital facility)	Applicable Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Inner Imaging (see page 66 for a detailed description)	Not applicable	No Charge

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
Any of above Diagnostic Procedures Performed in Hospital-based Outpatient Facility (other than emergency) are covered in the same manner except in circumstances where: As a matter of convenience for your physician, he/ she had these tests performed in a hospital setting as opposed to a freestanding ambulatory site. As a matter of convenience for you, you chose to have these tests performed within a hospital. Where the physician sent you to the hospital for these diagnostic tests, unless it was an issue relating to medical necessity, to which the Fund reserves the right to require your physician to substantiate. Where the claims associated with the diagnostic services you received in your physician office are being presented for payment with the Tax Identification number of a regional hospital, making it appear that the services you received were performed within the hospital facility itself.	Only payable for the following circumstances: • Tilt Table Testing • Pulmonary function testing • Pre-surgical testing done within 10 days of inpatient admission. • Mammograms • Breast Sonogram Payable same as free-standing if for above services All other services payable as a Non-Participating benefit	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
MEDICAL BENEFIT		
Dietician/Nutritionist The Plan allows up to six visits per calendar year and 18 lifetime visits for services performed by a licensed dietician. Any visit to a dietician will be combined with any service performed by a licensed nutritionist not to exceed the six visits per year or the lifetime limit of 18 visits Any benefits required under the ACA Preventive benefits will not be subject to this limitation for Participating Providers Visit maximums do not apply to treatment provided in conjunction with a Mental Health or Substance Use Disorder diagnosis	$30 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Digital Dermoscopy Examinations for the Early Detection of Malignant Melanoma / Skin Exams – DELM The Fund will allow up to 2 visits per calendar year. See page 67 details	$40 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Epidural Steroid Injections/Nerve Blockers Maximum three injections per calendar year	$40 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
Pre-Surgical Testing Diagnostic tests prescribed by your physician and completed in the same hospital as the scheduled surgery will be covered in full, provided the surgery takes place within 10days of testing and provided tests are related to, and necessary for, diagnosis and treatment of the conditions requiring surgery	$0 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Private Duty Nursing (Precertification required) Subject to $10,000 lifetime maximum	Not covered	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible up to $10,000 lifetime maximum
Surgery Surgeon/Physician/Professional Charges Assistant Surgeon if medically necessary Second or Third Surgical Opinion See page 81 for details	Specialist: $30 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Sleep Study (Precertification required) The Fund will cover two sleep studies per calendar year not to exceed $3,000 per calendar year combined for Participating and Non-Participating Providers. Annual $3,000 maximum may be met in one sleep study, upon which second sleep study will not be covered.	$0 Copayment (only covered in free-standing facility; when billed by hospital facility, covered as Non-Participating Provider)	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
Wellness/Preventive Benefits See page 68 for a detailed description of all the Wellness/Preventive benefits the Plan provides including Preventive Benefits as required under the Affordable Care Act.	**Participating/ In-Network Providers (PPO) You Pay**	**Non-Participating/ Out-of-Network Providers You Pay**
Annual Physical Exam (1 per calendar year) The Plan has contracted with Professional Evaluation Medical Group (PEMG). You may also utilize any Participating or Non-Participating Provider. See page 66 for details about the PEMG benefit.	$0 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Adult Diagnostic Screening required under ACA Preventive benefits (as described on page 68)	$0 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Newborn and Well-Child Care Covered services and the number of visits is based on the prevailing clinical standards of the American Academy of Pediatrics as described under the ACA Preventive benefits (described on page 68)	$0 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Well-Woman Care Covered services and the number of visits is based on the prevailing clinical standards of the GYN as described under the ACA Preventive benefits (described on page 68)	$0 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
EMERGENCY AND URGENT CARE		
Facility and Ancillary charges related to Emergency Medical Services to treat an Emergency Medical Condition provided in an Emergency Room See the Definitions section for information on what constitutes Emergency Medical Services for an Emergency Medical Condition	$200 Copayment (waived if admitted)	$200 Copayment (waived if admitted)
Non-Emergency Medical Services (those services that are NOT required to treat an Emergency Medical Condition) provided in an Emergency Room Services that are received in an Emergency Room but do not meet the Plan's definition of an Emergency Medical Services to treat an Emergency Medical Condition	20% of Fee Schedule plus balances above Maximum Allowed Amount after deductible	20% of Fee Schedule plus balances above Maximum Allowed Amount after deductible
Urgent Care Services	$30 Copayment	20% of Fee Schedule plus balances above maximum amount payable by the Plan after deductible
Emergency Air Ambulance (Precertification required) Transportation to nearest acute care Hospital for emergency inpatient admissions for life threatening medical emergencies	$0 Copayment	$0 Copayment
Emergency Land Ambulance Local professional ground ambulance to nearest Hospital when medically necessary	$0 Copayment	20% of Fee Schedule plus balances above Maximum Allowed Amount after deductible

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
MATERNITY CARE AND INFERTILITY TREATMENT		
Prenatal and Postnatal Care The Fund provides a benefit for prenatal and postnatal care including surgical procedures, obstetrical procedures, preoperative and postoperative care on an inpatient and outpatient basis, when performed by a physician, surgeon, specialist, certified nurse midwife, anesthetist or anesthesiologist for pregnancy and complications of pregnancy.	$0 copayment Payable under global allowance for delivery	20% of Fee Schedule plus balances above Maximum Allowed Amount after deductible
Therapeutic abortions and non-therapeutic abortions	$30 copayment	20% of Fee Schedule plus balances above Maximum Allowed Amount after deductible
Lab Tests, Sonograms and Other Diagnostic Procedures The Fund will pay for three sonograms during a pregnancy. Any sonogram beyond the three will not be paid unless Anthem Blue Cross Blue Shield receives a letter of medical necessity and approves the additional sonograms prior to the additional sonograms being rendered. Additional sonograms used to determine sex, size, weight of the fetus, or timing of the delivery are not considered medically necessary and will not be covered.	Payment varies according to the service which is provided. See applicable row for details.	20% of Fee Schedule plus balances above Maximum Allowed Amount after deductible
Routine Newborn Nursery Care (in Hospital)	Covered under the mother as part of global fee for delivery.	Not covered

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
Obstetrical Care (in Hospital or Birthing Center) One home care visit fully covered by Anthem if the mother leaves earlier than the 48-hour (or 96-hour) limit. The mother must request the visit from the hospital or a home health care agency within this timeframe. The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later. Services of a certified nurse-midwife affiliated with a licensed facility. The nurse-midwife's services must be provided under the direction of a physician. Parent education, and assistance and training in breast or bottle feeding, if available Circumcision of newborn males Special care for the baby if the baby stays in the hospital longer than the mother. Semi-private room Care for newborns includes preventive health care services, routine nursery care, circumcisions and treatment of disease and injury. Treatment of disease and injury includes treatment of prematurity and medically diagnosed congenital defects and birth abnormalities, which cause anatomical functional impairment.	$100/day to maximum of $250/stay	Not covered

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
Infertility Treatment (Maximum for Medical is $5,000 per calendar year and $5,000 for prescription drugs per calendar year for a total maximum of $10,000)	Payment varies according to the service which is provided up to the annual maximum.	20% of Fee Schedule plus balances above Maximum Allowed Amount after deductible up to the annual maximum
FACILITY SERVICES (INPATIENT AND OUTPATIENT SERVICES)		
Inpatient Facility/Acute Care Expenses including Inpatient Facility for the Diagnosis and Treatment of Mental Health and Substance Use Disorder (Alcohol/ Substance Use) (Precertification required) Payable for semiprivate room rate for 120 days of care during one confinement or multiple confinements that are not separated by 90 or more days. Private room will be payable at amount equal to the hospital's average semiprivate rate: Includes (any of the following when billed by hospital): Anesthesia and oxygen Chemotherapy and radiation therapy Diagnostic x-rays and lab tests General special/critical nursing care Intensive care Kidney dialysis (in-network only) Pre-surgical testing Diagnostic X-rays and lab tests, and other diagnostic tests such as EKG's, EEG's or endoscopies Oxygen and other inhalation therapeutic services and	$100/day copayment to maximum of $250 per calendar year	Not covered Out-of-Network Facility expenses are not covered; benefits are only provided in-network.

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
supplies and anesthesia (including equipment for administration) Blood and blood derivatives for emergency care, same-day surgery, or medically necessary conditions, such as treatment for hemophilia MRIs/MRAs, PET/CAT scans and nuclear cardiology services Operating and recovery rooms Special diet and nutritional services while in the hospital Cardiac care unit Services of a licensed physician or surgeon employed by the hospital Care related to surgery Breast cancer surgery (lumpectomy, mastectomy), including: - Reconstruction following surgery. - Surgery on the other breast to produce a symmetrical appearance. - Prostheses - Treatment of physical complications at any stage of a mastectomy, including lymphedemas - The patient has the right to decide, in consultation with the physician, the length of hospital stay following mastectomy surgery. Use of cardiographic equipment Drugs, dressings, and other medically necessary supplies		

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
Social, psychological, and pastoral services Reconstructive surgery associated with injuries unrelated to cosmetic surgery. Reconstructive surgery for a functional defect which is present from birth. Physical therapy including facilities, services, supplies and equipment for up to 30 days per calendar year. Cardiac Rehabilitation Facilities, services, supplies and equipment related to medically necessary medical care		
Skilled Nursing Facility (Precertification required) Up to 60 days per calendar year in a skilled nursing facility for medical care, nursing care or rehabilitation services if the care is under direct supervision of a physician, registered nurse (RN), physical therapist or other licensed healthcare provider.	$0 Copayment	Not covered Out-of-Network Facility expenses are not covered; benefits are only provided in-network
Rehabilitation/Residential Facility for Mental Health and Substance Use Disorder Treatment Only (Precertification required)	$0 Copayment	Not covered Out-of-Network Facility expenses are not covered; benefits are only provided in-network

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
Hospice (Precertification required) Up to 210 days per calendar year once in a covered person's lifetime. Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of six months or less. Hospice care can be provided in a hospice, in the hospice area of a network hospital, or at home, as long as it is provided by a network hospice agency.	$0 Copayment	Not covered Out-of-Network Facility expenses are not covered; benefits are only provided in-network
Outpatient Facility including Ambulatory Surgery, Same-day Surgery Facility and Outpatient Hospital Facility Blood and blood derivatives for emergency care, same-day surgery, or medically necessary conditions, such as treatment for hemophilia Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in the following settings until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare (in which case Medicare will become primary): - At home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures	$50 Copayment	Not covered Out-of-Network Facility expenses are not covered; benefits are only provided in-network

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
needed in the home to permit home dialysis treatment are not covered) - In a hospital-based or free-standing facility. Important Note About Medicare: When you have reached the end stage of kidney failure (renal impairment) that causes your Physician to recommend a kidney transplant or regular course of dialysis, you may be eligible for Medicare. It is important that individuals with end stage renal disease (ESRD) promptly apply for Medicare coverage, regardless of age. If you are eligible for Medicare but do not reenroll in both Medicare Part A and Part B after the 30-month coordination period is completed, this Plan will pay benefits as if you have enrolled. After the 30-month coordination period is completed, your claims will be reduced as secondary under this Plan regardless of your enrollment status under Medicare. As a result, in order to receive the maximum amount of coverage to which you may be entitled under Medicare, you should consider enrolling in and paying any premiums required for Medicare coverage, including Part B, no later than the end of the 30-month coordination period.		

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
Outpatient Facility for the Diagnosis and Treatment of Mental Health and Substance Use Disorders Including but not limited to partial hospitalization program services, intensive outpatient program services, counseling, and medication-assisted treatment when provided in an outpatient facility setting	$0 Copayment	Not covered Out-of-Network Facility expenses are not covered; benefits are only provided in-network
DURABLE MEDICAL EQUIPMENT AND SUPPLIES (Precertification required) Rental up to the purchase price (or purchase if less than rental) of medically necessary durable medical equipment; replacement of covered medical equipment because of wear, damage or change in patient's need, when ordered by a physician. Repair of durable medical equipment is not covered.		
Durable Medical Equipment Including: Hospital-type bed Corrective braces Wheelchair Oxygen equipment Sleep apnea monitor/Covers purchase if cost exceeds rental	$0 Copayment	20% of Fee Schedule plus balances above Maximum Allowed Amount after deductible
Orthotics (Precertification required) Foot orthotics covered when associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician	$0 Copayment	20% of Fee Schedule plus balances above Maximum Allowed Amount after deductible

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
Prosthetics Artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses Supportive devices essential to the use of an artificial limb Cochlear implants Hearing aids covered to maximum of $2,000 per ear once every five years Wigs as medically necessary to maximum of $650 per wig once per calendar year	$0 Copayment	20% of Fee Schedule plus balances above Maximum Allowed Amount after deductible
Medical Supplies Including: Catheters Oxygen Syringes	$0 Copayment	20% of Fee Schedule plus balances above Maximum Allowed Amount after deductible

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
HOME HEALTH CARE (Precertification required)		
Home Health Care (Precertification required) Up to 200 visits per calendar year; a visit equals 4 hours of care; includes home infusion therapy. A visit is defined as up to four hours of care. Care can be given for up to 12 hours a day (three visits). Your physician must certify home health care as medically necessary and approve a written treatment plan. Home health care services include: Part-time services by a registered nurse (RN) or licensed practical nurse (LPN) Part-time home health aide services (skilled nursing care) Physical, speech or occupational therapy, if restorative Medications, medical equipment and supplies prescribed by a doctor Laboratory tests No benefits are provided for custodial services, including bathing, feeding, changing or other services that do not require skilled care. See page 78 for more details on this benefit. Note: Visit maximums do not apply to treatment provided in conjunction with a Mental Health or Substance Use Disorder diagnosis.	$0 Copayment	Not covered

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
THERAPY/REHABILITATION (Precertification required)		
Cardiac and Pulmonary Rehabilitation (Precertification required) Up to 36 visits per calendar year a lifetime maximum of 120 visits Services not supervised by physician are not covered	Outpatient only: $0 Copayment per visit	Outpatient only: 20% of Fee Schedule plus balances above Maximum Allowed Amount after deductible
Physical Therapy and Rehabilitation (Precertification required) Inpatient limited to 30 days per calendar year licensed rehabilitation facilities only Outpatient limited to 30 visits per diagnosis combined in home, office or free-standing facility per calendar year. These maximums do not apply to treatment provided in conjunction with a Mental Health or Substance Abuse Use Disorder diagnosis. Outpatient facility not covered. Note: Visit maximums do not apply to treatment provided in conjunction with a Mental Health or Substance Use Disorder diagnosis.	Inpatient: Subject to inpatient Copayment Outpatient: $10 Copayment per visit Hospital Facility: Balances over $50 Maximum Allowed Amount after deductible (you are responsible for any balances over the $50 allowance) per visit	Inpatient: Not covered Balances over $50 Maximum Allowed Amount after deductible (you are responsible for any balances over the $50 allowance)

	PARTICIPATING/ IN-NETWORK PROVIDERS (PPO) YOU PAY	NON-PARTICIPATING/ OUT-OF-NETWORK PROVIDERS YOU PAY
Occupational Therapy, Speech and Vision Therapy (Precertification required) Outpatient limited to 30 visits per diagnosis combined in home, office or free-standing facility per calendar year if: Prescribed by a physician or in conjunction with a physician's services, Given by skilled medical personnel at home, in a therapist's office or in an outpatient facility, and Performed by a provider specifically licensed to provide these services. Note: Visit maximums do not apply to treatment provided in conjunction with a Mental Health or Substance Use Disorder diagnosis. The following therapy services are not covered: Tests, evaluations or diagnoses received within the 12 months prior to the doctor's referral or order for occupational, speech or vision therapy	Outpatient only: $10 Copayment per visit Hospital Facility: Balances over $50 Maximum Allowed Amount after deductible (you are responsible for any balances over the $50 allowance) per visit	Balances over $50 Maximum Allowed Amount after deductible (you are responsible for any balances over the $50 allowance)
Sclerotherapy and Vein Therapy (Precertification required) Maximum payable $2,600 for both legs per calendar year	Specialist: $30 copayment	20% of Fee Schedule plus balances above Maximum Allowed Amount after deductible

SwiftMD Program

With the SwiftMD Program, you and your family can speak with a doctor 24 hours a day, 7 days a week. You can also:

- Access care 24/7 from your home, office, or on the road via phone or videoconference.
- Update and check your SwiftMD Personal Health Record online.
- Get prescriptions for medications when appropriate.

As a SwiftMD Program participant, you can access medical care anytime, anywhere. All of their exclusive U.S.-trained and board-certified emergency and family practice physicians are capable of quickly and accurately diagnosing and treating a host of medical issues by way of a telephone call or videoconference. SwiftMD Program participants avoid drives across town, lengthy waits at the doctor's office, or sitting in an urgent care waiting room. You call the toll-free number or login online, answer a few simple health questions, and your case is forwarded to one of their physicians. Within an hour, a SwiftMD doctor will call you for a consultation. You will receive advice, a treatment plan, and a prescription if appropriate. There are no out-of-pocket costs, copayments or consulting fees for this service.

Call 877-WWW-SWIFT or 877-999-7943 or go to www.mySwiftMD.com.

PEMG Annual Physical

The Fund has contracted with Professional Evaluation Medical Group (PEMG) to provide each Participant with an annual physical and hearing test. The physical will be covered at 100%; there will be no charge for the services of PEMG for the annual physical and hearing test. Please note that although PEMG has successfully handled numerous physical examinations for Plan Participants, you are not required to utilize their services. You may elect to take your annual physical with any physician you're choosing. As such, the Fund will make payment for those services according to the network affiliation, or lack thereof, as outlined in this section.

Inner Imaging Program

The Fund has contracted with Inner Imaging to provide diagnostic screenings. Inner Imaging's EBT Body Scan can help diagnose the early stages of many diseases when they are treatable to help save lives. They offer the following screenings for any covered individual age 35 and older:

Lung Screening. This test, which is 11 times more sensitive than a traditional chest X-ray, is able to detect early-stage lung disease when it is most curable and can identify lung issues as small as 1mm. It can also detect early stages of emphysema, damage from work-related asbestosis exposure, pneumonia, and other infectious and inflammatory conditions. This is the number one form of cancer and approximately 200,000 cases are diagnosed each year. Existing survival rates are only 12%-15%. Survival rates improve to as much as 88% when cancers are diagnosed early. Conditions of the Lung include:

- Chronic Obstructive Pulmonary Disease (COPD)
- Fluid and or Scarring

- Emphysema
- Tumors or Suspicious Masses
- Lung Nodules
- Job Related Disorders including Asbestosis, Sarcoidosis and other contaminant exposure.
- Enlarged Lymph Glands in the Chest Cavity
- Pleurisy, Tuberculosis, Pneumonia

Abdomen & Pelvis Screening. This test is more frequently used for those with a family history of cancer. It is also used for those whose work environment places them in contact with carcinogenic, environmental, and other hazardous contaminants that can be cancer producing. Discovery of significant findings is approximately 12-15%. Conditions of the Vital Organs in the Abdomen and Pelvis include:

- Enlarged Organs and Lymph nodes
- Vascular Disease
- Diverticulosis and/or Diverticulitis
- Fatty Livers
- Ovarian Cysts and Fibroid Tumors
- Ventral, Inguinal and Hiatal Hernias
- Enlarged and Calcified Prostate Gland
- Abdominal Aortic Aneurysm
- Calcified Kidney and or Gall Stone Formation
- Cysts, Tumors
- Gastritis and Esophagus thickening due to Acid Reflux Disease
- Abnormal Seminal Vesicles
- Bladder Wall Thickening

Cancer Screening. Cancer affects people of all ages with the risk of most types increasing with age. Last year cancer caused 13% of all deaths. For most of us, the lifetime risk of cancer is approximately 20%. For others the risk is much higher because of family history, occupations, and exposures to carcinogens. Cancers are caused by abnormalities in the genetic material of cells. These abnormalities may be due to the effects of carcinogens; tobacco, radiation, chemicals, or infectious agents. Other cancer-promoting genetic abnormalities may randomly occur through errors in DNA replication or are inherited.

Definitive diagnosis requires the examination of a biopsy specimen, although the initial indication of malignancy can be symptomatic or radiographic imaging abnormalities. The prognosis of

cancer is most influenced by the type of cancer as well as the stage, or extent of the disease. Inner Imaging's screening has aided in the diagnosis of the following cancers:

- Thyroid
- Kidney
- Prostate
- Liver
- Uterus
- Lung
- Duodenal
- Colon
- Stomach
- Hairy Cell Leukemia

Preventive Care Services Required Under the ACA

This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010 (ACA). When provided by a Participating Provider, benefits will be payable at 100% with no cost-sharing (e.g., no copayments will be required), for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations.
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines and HRSA guidelines relating to services for women. If preventive services are received from a Non-Participating Provider, they will be subject to the Plan's applicable cost-sharing (e.g., subject to the Plan's Non-Participating deductible and coinsurance).
- In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Plan will determine whether a particular benefit is covered under this Preventive Services benefit.

All covered participants and dependents are eligible to obtain, without cost sharing, all required preventive services from a Participating Provider that are applicable to them (e.g., for their age group). This includes ACA-required pregnancy-related preventive services and well woman visits, which must be provided to dependent children (up to age 26) where an attending provider determines that the services are age and developmentally appropriate.

The following benefits are available under the Plan's Preventive Services benefit with no cost-sharing when received from a Participating Provider. In certain circumstances, as determined by the Plan, the preventive benefit is only payable with an appropriate diagnosis. The plan will impose cost-sharing for treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

Covered Preventive Services for Adults

- Abdominal Aortic Aneurysm one-time screening for men ages 65-75 who have ever smoked.
- Unhealthy alcohol use screening and counseling: screening and behavioral counseling interventions to reduce unhealthy alcohol use by adults ages 18 and older, including pregnant women, in primary care settings.
- Blood Pressure screening for all adults aged 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.
- Cholesterol screening (Lipid Disorders Screening) for adults aged 40-75 years.
- Colorectal Cancer screening using stool-based methods (such as fecal occult blood testing), sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient. The plan will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. The plan will not impose cost sharing with respect to the following services when these services are provided in connection with a screening colonoscopy and the attending provider determines the service is medically appropriate: bowel preparation medications, anesthesia services, a pre-procedure specialist consultation, or a pathology exam on a polyp biopsy.
- Depression screening for adults.
- Type 2 Diabetes screening in adults aged 40 to 70 who are overweight or obese, as part of cardiovascular risk assessment, with intensive behavioral counseling for those with abnormal blood glucose to promote a healthful diet and physical activity.
- Diet counseling for adults at higher risk for chronic disease.
- HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk.
- Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for adults with a body mass index of 30 kg/m2 or higher.
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk. Tobacco Use screening for all adults and cessation interventions for tobacco users.
- Syphilis screening for all adults at increased risk of infection.
- Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
- Screening for hepatitis C virus (HCV) infection in persons at high risk for infection and a one-time screening for HCV infection in adults born between 1945 and 1965.
- Annual screening for lung cancer with low dose computed tomography in adults ages 55 to 80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years.
- Screening for hepatitis B virus infection in adults at high risk for infection.

- Screening for latent tuberculosis infection in populations at increased risk.

Women's Preventive Care

Additional preventive care and screenings for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

- Well woman office visits for women beginning in adolescence and continuing across the lifespan, for the delivery of required preventive services.
- Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
- Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.
- BRCA counseling about genetic testing for women at higher risk. Women whose personal or family history is associated with – who have an ancestry associated with – an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will cover BRCA 1 or 2 genetic tests without cost sharing, if appropriate as determined by the woman's health care provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal, or peritoneal cancer.
- Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every 1 to 2 years for women aged 40 and older.
- Breast Cancer Chemoprevention counseling for women at higher risk. The Plan will pay for counseling by physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention. The Plan will also pay for risk-reducing medications (such as tamoxifene, raloxifene or aromatase inhibitors) for women at increased risk for breast cancer and at low risk for adverse medication effects.
- Comprehensive lactation support and counseling by a trained provider during pregnancy and for the duration of breastfeeding, and costs for renting breastfeeding equipment. The Plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the plan administrator.
- Cervical Cancer screening for women ages 21 to 29 with Pap smear every three years; for women ages 30-65, screening with Pap smear alone every three years, or screening with Pap smear and human papillomavirus testing every five years.
- Chlamydia Infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.
- FDA-approved contraceptives methods, sterilization procedures, and patient education and counseling for women of reproductive capacity. FDA-approved contraceptive methods, include barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. The plan may cover a

generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.

- Gonorrhea screening for sexually active women aged 24 and younger and in older woman who are at increased risk for infection, provided as part of a well woman visit. The Plan will pay for the most cost-effective test methodology only.
- Counseling for sexually transmitted infections, once per year as part of a well woman visit.
- Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool will be eligible for screening. The Plan will pay for the most cost-effective test methodology only.
- Rh Incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative.
- Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes.
- Screening for diabetes after pregnancy in women with history of gestational diabetes who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes.
- Tobacco Use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users. Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit.
- Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.
- Depression screening for pregnant and postpartum women and counseling interventions for pregnant and postpartum women at increased risk of perinatal depression.
- Screening for urinary incontinence annually.
- Screening for anxiety.
- Well baby and well child visits from ages newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will include the following age-appropriate screenings and assessments:
    - Developmental screening for children under age 3, and surveillance throughout childhood
    - Behavioral assessments for children of all ages
    - Medical history

- Anxiety screen for adolescent women
- Blood pressure screening
- Depression screening for adolescents ages 12 and older
- Vision screening at least once in all children 3 to 5 years to detect amblyopia or its risk factors
- Hearing screening
- Height, Weight and Body Mass Index measurements for children
- Autism screening for children at 18 and 24 months
- Alcohol and Drug Use assessments for adolescents
- Critical congenital heart defect screening in newborns
- Hematocrit or Hemoglobin screening for children
- Lead screening for children at risk of exposure
- Tuberculin testing for children at higher risk of tuberculosis
- Dyslipidemia screening for children at higher risk of lipid disorders
- Sexually Transmitted Infection (STI) screening and counseling for sexually active adolescents
- Cervical Dysplasia screening at age 21
- Oral Health risk assessment

- Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns).
- Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea.
- Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.
- Obesity screening for children aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.
- HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection.
- Counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
- Screening for hepatitis B virus infection in adolescents at high risk for infection.
- Application of fluoride varnish to the primary teeth of all infants and children through to age 5 starting at the age of primary tooth eruption, in primary care practices.
- Syphilis screening for adolescents who are at increased risk for infection.

- For adolescents, screening and counseling for interpersonal and domestic violence.

Immunizations

- **Routine adult immunizations** are covered for participants and dependents who meet the age and gender requirements and who meet the CDC medical criteria for recommendation. Doses, recommended ages, and recommended populations must be satisfied:

Immunization vaccines for adults

- Diphtheria/tetanus/pertussis
- Influenza
- Pneumococcal (polysaccharide)
- Hepatitis A
- Meningococcal
- Measles/mumps/rubella (MMR)
- Human papillomavirus (HPV)
- Zoster
- Hepatitis B
- Varicella

Immunization vaccines for children from birth to age 18

- Hepatitis B
- Diphtheria, Tetanus, Pertussis
- Pneumococcal
- Influenza
- Varicella
- Meningococcal
- Rotavirus
- Haemophilus influenzae type b
- Inactivated Poliovirus
- Measles, Mumps, Rubella
- Hepatitis A
- Human papillomavirus (HPV)

The preventive services referenced above will be covered in full when received from Participating Providers. Cost sharing (e.g., copayments) may apply to services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit and that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply. A list of the preventive services covered by the Plan is available on the Anthem website at www.anthembluecross.com or will be mailed to you upon request. You may request the list by calling the Customer Service number on your identification card.

Diabetic Management

Often, having a team of physicians or specialists can improve diabetes care. All participants with diabetes should see a health care provider who will help them learn to manage their diabetes and who will monitor their diabetes control. Your team of physicians might include:

- a physician such as an internist, a family practice doctor, or a pediatrician;
- an endocrinologist (a specialist in diabetes care);
- a dietitian, who is a certified diabetes educator;
- a podiatrist (for foot care);
- a cardiologist (for heart care); and
- an ophthalmologist (for eye care).

Diabetes self-management education and diet information, including:

- Education by a physician, certified nurse practitioner or member of their staff.
- At the time of diagnosis.
- When the patient's condition changes significantly.
- When medically necessary.
- Education by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian when referred by a physician or certified nurse practitioner. This benefit may be limited to a group setting when appropriate.
- Home visits for education when medically necessary.

Emergency Care

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of a hospital in Anthem's network or the PPO network of another Blue Cross and/or Blue Shield plan. Benefits for treatment in a hospital emergency room are limited to the initial visit for an emergency condition. A Participating Provider must provide all follow-up care in order to receive maximum benefits. Remember: You will need to show your Identification Card (I.D.) when you arrive at the emergency room.

Emergency Care/Services in an Emergency Room

Emergency Service/Care to treat an Emergency Medical Condition (as defined in the Definition section of this Booklet) is covered in the hospital emergency room. To be covered as Emergency Care, the condition must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency care, the condition would:

- Place your health in serious jeopardy.
- Cause serious problems with your body functions, organs or parts.
- Cause serious disfigurement.
- In the case of behavioral health, place others or oneself in serious jeopardy.

Sometimes you have a need for medical care that is not an emergency (i.e., bronchitis, high fever, sprained ankle), but cannot wait for a regular appointment. If you need urgent care, call your physician or your physician's backup. You can also call 24/7 NurseLine at 877-TALK2RN (825-5276) for advice, 24 hours a day, seven days a week or contact SwiftMD at 877-999-7943 for an online/telephone consultation.

Emergency services are covered:

- without the need for any prior authorization determination, even if the services are provided on an out-of-network basis;
- without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility, as applicable, with respect to the services;
- without imposing any administrative requirement or limitation on out-of-network emergency services that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities;
- without imposing cost-sharing requirements on out-of-network emergency services that are greater than the requirements that would apply if the services were provided by a participating provider or a participating emergency facility; By counting cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your deductible and out-of-pocket maximum in the same manner as those received from a Participating Provider.by calculating the cost-sharing requirement for out-of-network emergency services as if the total amount that would have been charged for the services were equal to the recognized amount for the services; and
- your cost sharing amount for Emergency Services from Out-of-Network Providers will be based on the lessor of billed charges from the provider or the Qualified Payment Amount (QPA).

Non-Emergency Services by Non-Participating Providers

Certain Non-Emergency services by non-participating providers at participating facilities must be covered based on In-Network cost-sharing. With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a nonparticipating provider at a participating facility, the items or services are covered by the plan:

- With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a participating provider.
- By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such participating provider were equal to the recognized amount for the items and services.
- By counting any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a participating provider.

- Your cost sharing amount for Non-Emergency Services at Participating facilities by Non-Participating Providers will be based on the lessor of billed charges from the provider or the QPA.

Please note, if a non-participating provider satisfies the notice and consent criteria, the non-Emergency services performed by the non-participating providers at the participating facilities do not have to be covered based on in-network cost-sharing.

- Non-Emergency items or services performed by a nonparticipating provider at a participating facility will be covered based upon your out-of-network coverage if:
    - at least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a nonparticipating provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any participating providers at the facility who are able to treat you, and that you may elect to be referred to one of the participating providers listed; and
    - the participant or beneficiary gives informed consent to continued treatment by the nonparticipating provider, acknowledging that the participant or beneficiary understands that continued treatment by the nonparticipating provider may result in greater cost to the participant or beneficiary.
    - The notice and consent exception does not apply to Ancillary services and items, or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider satisfied the notice and consent criteria and therefore these services will be covered:
    - with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a participating provider;
    - with cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the recognized amount for the items and services; and
    - with cost-sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

Emergency Air Ambulance

Air ambulance is provided to transport you to the nearest acute care hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care when the following conditions are met:

- Your medical condition requires immediate and rapid ambulance transportation and services cannot be provided by land ambulance due to great distances, and the use of land transportation would pose an immediate threat to your health.
- Either the point of pick-up is inaccessible by land vehicle or great distances, or other obstacles (for example heavy traffic) prevent your timely transfer to the nearest hospital with appropriate facilities.

- Services are covered to transport you from one acute care hospital to another, only if the transferring hospital does not have adequate facilities to provide the medically necessary services needed for your treatment as determined by the Plan, and use of a land ambulance would pose an immediate threat to your health.

If the condition for coverage for air ambulance services has not been met but your condition did require transportation by land ambulance to the nearest acute care hospital, the Plan will only pay up to the amount that would be paid for land ambulance to that hospital.

If you receive air ambulance services that are otherwise covered by the Plan from an Out-of-Network provider, those services will be covered by the Plan as follows:

- The air ambulance services received from an Out-of-Network provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an In-Network provider.
- In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by an In-Network provider of air ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any cost-sharing payments you make with respect to covered air ambulance services will count toward your In-Network deductible and In-Network out-of-pocket maximum in the same manner as those received from an In-Network provider.

Emergency Land Ambulance

The Plan will provide coverage for land ambulance transportation to the nearest acute care hospital, in connection with emergency room care or emergency inpatient admission, provided by an ambulance service, when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- placing the Participant's health afflicted with a condition in serious jeopardy, or for behavioral condition, place the health of a Participant or others in serious jeopardy; serious impairment to a person's bodily functions;
- serious dysfunction of any bodily organ or part of a person; or
- serious disfigurement to the Participant.

If need for care is not available locally, the Plan will pay for intra-facility ambulance (including air ambulance) transportation outside your local area to the closest facility that can provide care and only if the transferring hospital does not have adequate facilities to provide the medically necessary services needed for your treatment as determined by Anthem. Payment for transportation to another facility located further away will be used on how much it would cost for transportation to the closest facility.

Non-Emergency Ambulance Transportation. The Plan covers non-emergency ambulance transportation by a licensed ground ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:

- from a non-participating Hospital to a participating Hospital;

- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective Acute care Facility; or
- from an Acute Facility to a Sub-Acute setting.

The Plan does not cover:

- travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by Anthem Blue Cross Blue Shield, even though prescribed by a Physician; or
- non-ambulance transportation such as an ambulette, van or taxicab.

Hospice Care

The Plan covers up to 210 days of hospice care in a covered person's lifetime. Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of 6 months or less. Hospice care can be provided in a hospice, in the hospice area of a network hospital, or at home, as long as it is provided by a network hospice agency.

- Hospice care services, including:
  - Up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN).
  - Medical care given by the hospice doctor.
  - Drugs and medications prescribed by the patient's doctor that are not experimental and are approved for use by the most recent Physicians' Desk Reference.
  - Physical, occupational, speech and respiratory therapy when required for control of symptoms.
  - Laboratory tests, X-rays, chemotherapy, and radiation therapy.
  - Social and counseling services for the patient's family, including bereavement counseling visits until one year after death.
  - Transportation between home and hospital or hospice when medically necessary.
  - Medical supplies and rental of durable medical equipment.
  - Up to 14 hours of respite care in any week.

Home Health Care

Home health care can be an alternative to an extended stay in a hospital or a stay in a skilled nursing facility. You receive coverage for home health care and home infusion therapy. Home infusion therapy is a service sometimes provided during home health care visits. You are eligible for up to 200 home health care visits per year. A visit is defined as up to four hours of care. Care can be given for up to 12 hours a day (3 visits). Your physician must certify home health care as medically necessary and approve a written treatment plan. If you receive services from an In-Network home health care agency or home infusion supplier, the provider cannot bill you for covered services.

If you receive a bill from one of these providers, contact Participant Services at 800-553-9603. The Fund will provide home health care when this care is given after a hospitalization and provided care begins within 7 days after discharge with a participating state certified home care agency. Home care benefits are available under a physician-approved plan of treatment when the necessary services are rendered through a network participating, state-certified home health agency. Benefits will be provided only if the patient is homebound and hospitalization or confinement in a skilled nursing facility would otherwise have been required. Covered services include:

- Part-time professional nursing.
- Part-time home health aide services (up to a TOTAL of four hours of such care is equal to one home care visit).
- Physical, occupational, or speech therapy if restorative.
- Medical supplies, drugs and medicines prescribed by a physician, and necessary laboratory services.
- Home health care services include:
    - part-time services by a registered nurse (RN) or licensed practical nurse (LPN);
    - part-time home health aide services (skilled nursing care);
    - physical, speech or occupational therapy, if restorative;
    - medications, medical equipment, and supplies prescribed by a doctor; and
    - laboratory tests.

The following home health care services are not covered:

- Custodial services, including bathing, feeding, changing or other services that do not require skilled care.
- Out-of-network home infusion therapy.

Infertility Treatment

The Fund will allow $5,000 per infertility treatment per year for Medical and $5,000 per year for Prescription Drugs. The Fund will not make payment for any service rendered to any individual other than the Participant or legal spouse. A Participant's infertility benefit cannot be combined with another participant's infertility benefit to create a larger benefit. The Fund covers the following up to the above maximum per year:

- Artificial insemination, intrauterine insemination and dilation and curettage (D&C), including any required inpatient or outpatient hospital care that would correct malformation, disease or dysfunction resulting in infertility; and services in relation to diagnostic tests and necessary procedures.

- Services to determine infertility or in connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered are:
    - hysterosalpingogram
    - endometrial biopsy
    - sono-hysterorgram
    - testis biopsy
    - blood tests
    - hysteroscopy
    - laparoscopy
    - post-coital tests
    - semen analysis
    - ultrasound and
    - other medically necessary diagnostic tests and procedures, unless excluded by law.
- Advanced reproductive technology procedures are covered for participants who are infertile and who have failed to achieve a pregnancy through the use of other generally acceptable methodologies of treating infertility:
    - In-vitro Fertilization (IVF);
    - Zygote Intrafallopian Transfer (ZIFT);
    - Gamete Intrafallopian Transfer (GIFT);
    - Intracytoplasmic Sperm Injection (ICSI);
    - medically necessary and appropriate diagnostic workup and radiology services and pathology and laboratory services; and
    - pathology and laboratory services, including hormonal assays; swim up semen analysis, as appropriate; fertilization and embryo culture.
- Prescription drugs approved by the FDA specifically for the diagnosis and treatment of infertility that are not related to any excluded services are covered, subject to all the conditions, exclusions, limitations and requirements that apply to all other prescription drugs under this Plan. Refer to page on page 90 for information regarding your prescription drug coverage.

The following are not covered:

- Any procedure for which donated ova or donated sperm are used.
- Embryo cryopreservation of fees associated with it.
- Fallopian tube ligations and vasectomy reversals.
- With respect to a surrogacy or gestational carrier arrangement, no coverage for maternity or delivery expenses of a woman who is not a covered plan participant.
- Experimental, investigational, or obsolete procedures, as defined in this document.
- Services requested which are not medically appropriate, including but not limited to ovarian failure or obesity wherein the chances of successful pregnancy are substantially diminished.

- Services not specifically listed as covered in this SPD.
- Pre-implantation testing/genetic testing.

Prosthetics and Medical Supplies

- Prosthetics, orthotics, and durable medical equipment, including:
  - Artificial arms, legs, eyes, ears, nose, larynx, and external breast prostheses;
  - Prosthetic lenses if organic lens is lacking;
  - Supportive devices essential to the use of an artificial limb;
  - Corrective braces; and
  - Wheelchairs, hospital-type beds, oxygen equipment, sleep apnea monitors.
- Rental (or purchase when more economical) of medically necessary durable medical equipment.
- Replacement of covered medical equipment because of wear, damage or change in patient's need, when ordered by a physician.
- Reasonable cost of repairs and maintenance for covered medical equipment.
- Disposable medical supplies such as syringes.

Skilled Nursing Facilities

Prior approval is necessary before Blue Cross Blue Shield can make payment for this benefit. Up to 60 days per calendar year in a skilled nursing facility for medical care, nursing care or rehabilitation services if the care is under direct supervision of a physician, registered nurse (RN), physical therapist or other licensed healthcare provider.

Entry into a skilled nursing facility will be approved when the following conditions have been met:

- the patient has had at least 3 consecutive days of inpatient hospitalization;
- entry occurs immediately after discharge from an inpatient hospitalization; and
- the physician provides a written treatment plan, length of stay, explanation of services needed and benefits of care.

Surgery and Anesthesia

The Plan covers professional charges associated with surgery and anesthesia as follows:

- Expenses of Surgeons and Anesthesiologist.
- One assistant surgeon per operation when the hospital does not employ a house staff of surgeons/surgical residents or when a surgical resident is unavailable to assist or when required by law. Payable if medically necessary based on complexity of surgery.
- When multiple surgical procedures are performed through the same incision during the same operation, Blue Cross Blue Shield only reimburses for one procedure—the one with the highest allowance. If two or more separate incisions are required at two or more different

sites, reimbursement will occur at the allowed amount for the procedure with the highest allowance and at 50% of the allowed amount for the other procedure.

- If co-surgeons are medically necessary, payment will be 50% for each co-surgeon. Most hospitals, clinics and freestanding medical facilities contract with independent surgeons, physicians, and other medical professionals. These individuals are independent contractors and not on these facilities' payrolls. Therefore, do not assume that all the medical providers assisting you during your inpatient or outpatient surgery participate in the network. Speak to your surgeon about utilizing only participating medical providers whenever he or she enlists the services of other medical professionals such as assistant surgeons, anesthesiologists, co-surgeons, laboratory technicians, pathologists, radiologists, etc. Payment for post-operative visits and consultations conducted within 90 days of your surgery are inclusive in the payment made by the plan to the surgeon.

Weight Loss Surgery (Bariatric Surgery/Gastric Bypass). The Plan covers bariatric/gastric bypass surgery only if it is considered Medically Necessary and is not experimental/investigational/unproven. The only surgeries that are payable under this Plan are: vertical banded gastroplasty, Roux-en-Y gastric bypass, laparoscopic adjustable silicone gastric banding (e.g., LAP-BAND®, REALIZE™), or biliopancreatic diversion with duodenal switch (BPD/DS) The Plan only covers bariatric surgery for covered individuals who meet the following criteria. In order to be eligible for this benefit, the covered individual must:

- be 18 years of age or older;
- have a body mass index (BMI) of 40 or greater and at least 100 pounds over normal weight for more than five years; or a BMI of 35-39.9 for more than 5 years with at least one clinically significant co-morbidity including but not limited to cardiovascular disease, diabetes, high blood pressure unable to be controlled with medication/medical management, coronary artery disease or pulmonary hypertension; and
- provide proof of 6 continuous months of non-surgical methods of weight reduction supervised, monitored, and documented by a medical physician or health professional during the past 2 years.
- Precertification is required for these benefits. For Participating Providers, contact Anthem Medical Management (see page 2 for details). For Non-Participating Providers, a letter of medical necessity along with the patient's complete medical report, medical diagnosis and supporting documentation is required in order to obtain prior approval and to determine that surgery is not being performed for any cosmetic reason.

Future "Band Adjustments" are covered only up to the first year following the surgery and requires prior approval. Panniculectomy or re-contouring to remove loose skin, as a result of bariatric, or stomach stapling surgery, will not be paid for by Blue Cross Blue Shield. This includes, but is not limited to, tummy tuck, belt lipectomy, brachioplasty, breast lift/reduction, and thighplasty. Blue Cross Blue Shield will not pay for treatment of any condition or illness resulting from the participant's decision to have Gastric Bypass, including, but not limited to, the reversal of the Gastric Bypass Surgery.

Lasik Surgery. Precertification is required. The Plan allows up to a maximum global allowance of $1,600 for each eye regardless of whether you use a Participating Provider or a Non-Participating Provider. You will be responsible for any amounts over the global allowance.

No payment will be made for this procedure if you wear glasses or contact lenses, glasses or contact lenses can correct the vision condition or if the primary reason for the procedure is because individual no longer wants to wear glasses or contact lenses.

Reconstructive and Corrective Surgery. Reconstructive and corrective surgery is covered only when:

- the surgery is incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- the surgery is performed to correct a congenital birth defect of a dependent child which has resulted in a functional defect.

Federal law requires group health plans that cover mastectomies to cover reconstructive surgery or related services following a mastectomy. The Women's Health and Cancer Rights Act of 1998 essentially guarantees coverage to any Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with that mastectomy. Under this law, the Fund is required to provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

Organ Transplant. Care must be coordinated with the Catastrophic Case Management

- All transplants must be performed at Participating hospitals that have been specifically approved and designated to perform these procedures.
- Only transplants for the following are covered:
    - Bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich syndrome
    - Cornea
    - Heart
    - Heart/lung
    - Kidney
    - Liver
    - Pancreas (when the condition is not treatable by use of insulin therapy)

Recipient. Benefits are provided for recipient expenses. A "recipient" is an individual who undergoes a surgical operation to receive a body organ transplant.

Donor. Benefits for donor expenses are limited to donors who donate an organ to recipients who are covered participants under the Local 15 Welfare Fund.

The Fund does not cover:

- Travel expenses, lodging, meals or other accommodations for donors or guests.

- Donor search fees.
- The expenses of a Participant acting as a donor for a non-participant of the Plan.

Mental Health Treatment

Eligible health services include the treatment of mental health disorders as follows:

- In-Network inpatient room and board at the semi-private room rate, and other services and supplies related to the condition that are provided during the stay in an inpatient Hospital or Facility.
    - Outpatient treatment received while not confined in an inpatient Hospital or Facility, including:
    - Office visits to a physician or licensed mental/behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor; and
    - Telemedicine consultation/visits with a licensed provider.
- Other outpatient mental health treatment such as Partial Hospitalization Treatment provided in an In-Network Facility or program for mental health treatment and Intensive Outpatient Program provided in an In-Network Facility or program for mental health treatment.

Substance Use Disorders Treatment

Eligible health services include the treatment of substance abuse provided by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider as follows:

- In-Network inpatient room and board at the semi-private room rate, and other services and supplies related to the condition that are provided during the stay in an inpatient Hospital or Facility.
- Outpatient treatment received while not confined in an In-Network Inpatient Hospital or Facility, including:
    - Office visits to a physician or licensed mental/behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor; and
    - Telemedicine consultation/visits with a licensed provider.
- Other outpatient substance abuse treatment such as Outpatient detoxification provided in an In-Network Facility, Partial Hospitalization treatment provided in an In-Network Facility or program for treatment of substance abuse and Intensive Outpatient Program provided in an In-Network Facility or program for treatment of substance abuse.

EXCLUSIONS AND LIMITATIONS

In addition to services specifically excluded or limited as outlined in the prior sections of this SPD, the Plan does not cover the following:

General Exclusions and Limitations Under the Plan

No benefits are payable under the Plan for the services identified below:

- Any injury or illness or services and supplies that arise out of or in the course of employment that are compensable under workers' compensation, occupational disease, or similar laws, whether or not the right under the law is asserted.
- An injury or illness resulting from or occurring during an attempt to commit or commission of a misdemeanor or felony or participation in a public disturbance or riot, unless as a result of a medical condition or mental health condition or as a victim of an act of domestic violence.
- An injury or illness resulting from past or present military service or caused by or arising from an act of war, whether declared or not, or a conflict involving armed forces.
- An intentionally self-inflicted injury or illness, unless as a result of a medical condition or mental health condition or as a victim of an act of domestic violence.
- Anesthesia services that were administered by the operating surgeon, his or her assistant or an employee of a hospital or similar institution or when billed by more than one provider.
- Any balance or fee for services and goods not covered by the Plan.
- Any balance remaining after the Plan's payment for services performed by non-participating providers.
- Any charges to the extent that they are considered unreasonable by the Plan.
- Any expense, charge or fee incurred for missed appointments.
- Any expenses or charge for the treatment of craniomandibular or temporomandibular joint (TMJ) disorders unless proven to be medically necessary.
- Any expenses that are in excess of the Fund's Maximum Allowed Amount.
- Any expenses or charges for services or supplies not Medically Necessary or are considered Experimental/Investigational (as defined in this document) or not recommended by a doctor.
- Any expenses incurred after coverage ends.
- Any expenses or charge for which the covered person does not have to pay. For example, when a provider of care does not usually collect charges in the absence of insurance coverage, no benefits are provided. This exclusion applies even if charges are billed.
- Any expenses or charges for services or supplies which are chiefly for instruction, education or training by or for a provider.
- Any expense, fee or charge associated with Non-Participating facilities including Hospitals, surgical centers, and other outpatient Facilities.

- Any expense or charge associated with adoption or surrogate parentage.
- Any expenses for the creation, collection or copying of medical records or fees to complete medical forms.
- Any expense associated with the diagnosis and treatment infertility above the allowance described in this SPD.
- Any expenses for Non-Participating Providers that require precertification where none has been granted.
- Any loss, expense, or portion thereof, for which mandatory automobile non-fault benefits are recovered or recoverable.
- Any loss, expense or charge that results from cosmetic surgery treatment which includes surgery or medical treatment to improve or preserve physical appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance, but not to treat physical function. The Plan does cover Medically Necessary Reconstructive Services as required by law.
- Any loss, expense or charge that results from reconstructive surgery, except if required by law (e.g., breast symmetry after a mastectomy), or the procedure or treatment is intended to improve bodily function, repair a functional defect and/or to correct deformity or disfigurement resulting from injury/trauma or congenital anomaly (birth defect) of newborn children.
- Any service rendered by practitioners beyond the scope of their licenses.
- Assistant surgeon fees, except for procedures when this assistance is Medically Necessary.
- Biofeedback counseling, treatments or testing.
- Birthing center charges at non-participating facilities.
- Blood handling.
- Children who do not meet the definition of dependent.
- Chelating therapy except for acute arsenic, gold mercury, and lead poisoning or for other foreign substances induced while performing the daily duties or function of an operating engineer.
- Commode raised toilet seat and shower seat.
- Dental benefits (including oral surgery and anesthesia) are not payable under the Medical benefits. See the Dental section of this SPD for details on what is payable by the Plan. Under no circumstances does the Plan cover fluoride treatment (unless required by the ACA), sealants, dental guards, orthographic surgery, or cone beam scans.
- Provider/Professional charges from Non-Participating Providers that are in excess of the Plan's Maximum Allowed Amount.
- Durable medical equipment without Precertification.

- Durable medical equipment which is for non-medical use (whether prescribed by a doctor or not), such as heating pads, whirlpool baths, exercise devices, ramps or handrails, air conditioners, purifiers, humidifiers, lifts for wheelchairs, including lifts for staircases, or items of furniture with the exception of such medical equipment being provided pursuant to the requirements of WHCRA.
- Medical supplies that are single use or considered "throwaway", such as tubes, hoses, gloves, or gauzes.
- Any Epidural Injections after the fourth that have not received prior approval.
- Exogenous obesity, or weight reduction and control expenses or charges that result from appetite control or any treatment of obesity except as specifically outline as covered in this document and/or required by law.
- Experimental/investigational treatments (see the Definitions section for a definition of Experimental/Investigational),
- Facility charges from non-licensed facilities.
- Foster children, grandchildren, or siblings, unless adopted by the Participant, are not covered.
- Fitting, repairing or replacement batteries for hearing aids.
- Gene therapy, whether those therapies have received approval from the U.S. Food and Drug Administration (FDA) or are considered experimental or investigational. Illustrative examples of gene therapy include Chimeric Antigen Receptor T-Cell (CAR-T) Therapies such as Kymriah and Yescarta, Luxturna, Zolgensma, Rethymic and Ryplazim, but new applications for gene therapies are submitted every year.
- Genetic testing except as required as a preventive benefits under the ACA, state-mandated newborn screening tests for genetic disorders, fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), alpha-fetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary, and genetic testing recommended by the American College of Obstetrics and Gynecology for pregnant women such as prenatal genetic screening for cystic fibrosis. Genetic counseling is only covered as required under the ACA preventive benefits.
- Governmental services/programs except where required by law or otherwise covered as described in this document.
- Home Care without prior approval and as specifically described in this document.
- Inappropriate billing or charges that include services usually provided without charge or performed by hospital or institutional staff which are billed separately from other hospital or institutional services or when a Non-Participating Provider waives cost sharing. If the Plan determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a covered service without the Plan's express consent, then the Plan in its sole discretion shall have the right to deny the payment of benefits in connection with the covered service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven, or reduced, regardless of whether the provider represents that you remain responsible for any amounts that the Plan does not cover.

- Injuries and diseases covered under any workers' compensation programs.
- Lap band adjustments one year or more after the surgery.
- Lasik Surgery without prior approval.
- Expenses for educational services related to learning disabilities, delayed speech development, developmental delay, behavioral problems, reading, dyslexia, educational delays, or vocational disabilities or special education.
- Marriage/relationship counseling.
- Maternity services and supplies provided by a hospital or birthing center that includes parent education, assistance, and training in great or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments unless required by law under the ACA preventive benefits.
- Medical services or supplies furnished in or by a federal, state, or local government agency or program or by a hospital or institution owned thereby, unless required by law.
- Medical services or supplies, including prescription drugs that are considered educational, investigational, or experimental, including any treatment, drug or supply not recognized as accepted medical practice in the United States or any items requiring governmental approval not granted at the time service is rendered.
- Medical, dental or vision services or supplies furnished by an individual who ordinarily resides in your home or is related to you by blood or marriage.
- Nebulizer supplies (i.e., tubes, masks, disposable supplies).
- Nutritional supplements including but not limited to eternal formulas and modified solid food products. (Unless in connection with an eating disorder).
- Occupational therapy without prior approval.
- Oocyte cryopreservation.
- Orthotic casting, fitting, or molding.
- Orthotics without prior approval.
- Orthotripsy without prior approval.
- Osteopathic Manipulation provided by any provider who is not licensed to provide this service.
- Pain management or palliative treatments.
- Panniculetctomy.
- Physical therapy without prior authorization or provided by a licensed to perform services (e.g., physical therapy) for which they are billing.
- Podiatry care for surgical procedures (unless such treatment is rendered at the written request of a licensed provider).
- Refraction.
- Reversal of sterilization.

- Services relating to reversal of gastric bypass or bariatric surgery.
- Sonograms only to determine size of the fetus or timing of delivery.
- Strapping included in office visit fees.
- Surgical Trays.
- Expenses for memberships in or visits to health clubs, physical fitness or exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, fitness instructors, work hardening and/or weight training services, ergonomic chairs/desks, exercise/activity/health monitoring/tracking devices, or software applications including smartwatches/jewelry and wireless or wearable sensors/trackers or educational, music or art therapies.
- Expenses for which a third party is liable or required to pay because of negligence or other tortious or wrongful act of that third party, except as provided for under the Plan. See the Subrogation section of this Booklet.
- Travel, even if associated with treatment and recommendation by a doctor.
- Vitamins, including over-the-counter vitamins except as required under the preventive services of the ACA.
- Services required by the Employer as a condition of employment; services rendered through a medical department, clinic, or other similar service provided or maintained by the Employer.

PRESCRIPTION DRUG BENEFITS

The Plan provides prescription drug coverage, which is self-insured and OptumRx is the pharmacy benefits manager (PBM). The following explanations will help you understand the program:

- **Generic Drug** is defined by its official chemical name and is an equivalent to a brand name medication. All drugs, including generics, must meet the same U.S. Food and Drug Administration (FDA) standards for quality, strength, purity, effectiveness, stability, and safety.
- On average, generic medications can save about half the cost of the brand name medications, but for some medications this savings can be as great as 90%. This can be a significant source of savings for you and the Welfare Fund. In general, the savings achieved by using generic medications will help control the cost of health care while providing quality medications.
- You should discuss with your physician if a generic equivalent is available, and appropriate, for any prescription you need filled. Your physician or pharmacist can assist you in substituting generic medications when appropriate. While you pay the same percentage of your covered prescription drug expenses, whether you receive a generic medication or a brand name medication, since brand name medications cost more, you pay more because you're paying the same percentage of a higher amount. The Fund encourages you to use generic medications whenever possible to lower the amount you pay.
- **Brand Name Medication** is a medication sold by a pharmaceutical company under a trademark-protected name. Brand name medications can only be produced and sold by the company that holds the patent for the drug.
- **Formulary Brand Drugs** is a list of generic and brand-name drugs that are covered by the Plan. The list is determined by a medical committee of pharmacists and physicians appointed by Plan's pharmacy benefit manager. The pharmacy benefits manager chooses which drugs to include on the formulary based on each drug's effectiveness, safety and cost. Drugs that appear on the formulary are covered by the Plan. Drugs that are not included in the formulary are not covered by the Plan unless they are found to be medically necessary. The list can change at any time, as determined by OptumRx.
- There may be exceptions for coverage of a non-formulary drug in certain circumstances. Requests for non-formulary drugs are evaluated on the basis of medical necessity, the individual's health and safety and the existence of other comparable alternatives. If you or your physician would like to request an exception, you or your physician must contact the Fund Office directly.
- An important part of the list is giving you choices so you and your doctor can choose the best course of treatment for you. Since the list may change, you are encouraged to visit OptumRx's website, which should be listed on your ID card. This website is the best source for up-to-date information about all of the medications your pharmacy benefit covers, possible lower-cost options and cost comparisons.

- **Non-Formulary Brand Drugs** are those medications that are not listed on the Plan's formulary. Not all prescription drugs are on the formulary. Non-formulary (or off-formulary drugs) are excluded (i.e., not covered) by the Plan. If you attempt to fill a prescription that is not on the formulary, the pharmacist will generally let you know and work with the prescribing physician or health care practitioner to find a comparable drug on the formulary to ensure coverage. If you fill a prescription for a non-formulary drug, you will pay the entire cost for the prescription (unless an exception is granted in accordance with the above).

How to Obtain Your Prescription Drugs

There are three different ways for you to obtain a prescription medication (which are described below):

- from Retail Pharmacies using a prescription drug card;
- by Mail Order; or
- through the exclusive Specialty Pharmacy.

Prescriptions are filled or checked by a registered pharmacist regardless of how you choose to purchase them. The following cost-sharing applies when you receive your prescription:

- **Deductible** – The deductible is the amount you and each eligible dependent (and not the Plan) pay each year for prescription drugs before the Plan begins to pay any benefits. The annual prescription drug deductible is $25 per covered individual per calendar year.
- **Coinsurance** – Once you have met the individual annual deductible, the Plan will pay 80% and you will be responsible for 20% of the balance of the cost of the medication up to the amount allowed by the Plan. The 20% that you pay is called coinsurance.
- **Out-of-Pocket Limit** – The out-of-pocket limit for in-network prescription drugs is $8,100 per individual and $16,200 for two or more individuals (family). Once you meet this out-of-pocket limit during the calendar year, the Plan will pay 100% of your prescription drugs for the remainder of the calendar year (until December 31st). This amount may be adjusted annually in accordance with federal guidelines. You will be required to show proof of payment.

  This limit does not include copayments incurred for Specialty Drugs eligible for the Copayment Assistance Program for any individuals, whether or not they participate in the program.

  If a participant selects a brand name prescription drug in circumstances in which a generic drug was available and medically appropriate (as determined by the individual's personal physician), the participant will have to pay an added amount equal to the difference between the cost of the brand name drug and the cost of the generic drug. This added amount paid by the participant does not accumulate to meet the out-of-pocket limit.

Retail Pharmacies

Participating Pharmacy

When you need to fill an occasional prescription, such as for antibiotics for an infection, using a retail pharmacy is most convenient. By filing prescriptions at a participating pharmacy, you minimize your out-of-pocket costs. Most nationwide retail drugstore chains as well as thousands of independent retail pharmacies participate in the OptumRx Network. To find out if your pharmacy participates in the program, call OptumRx (contact information can be found at the beginning of this Booklet).

You will receive an OptumRx prescription drug identification card when you first become eligible for health benefits. With the prescription card, you can obtain any covered drug at the discounted in-network price by paying the applicable copayment. Your prescription drug card allows you to purchase up to a 30-day supply at a time. If you try to fill your prescription at a participating drugstore pharmacy without your ID card, your purchase may be delayed until your coverage is verified. If your coverage cannot be verified, you may still fill the prescription and submit a bill for payment provided you are eligible for Fund coverage at the time you fill the prescription.

Non-Participating Pharmacy

If you use a non-participating pharmacy, you will have to pay the full prescription cost and send the claim receipt to the Fund Office for reimbursement. You will be responsible for the deductible and the 20% coinsurance based on the full cost of the drug as well as any balances over the amount the Fund reimburses and the cost of the drug. In addition, these expenses will not count toward the Out-of-Pocket Maximum.

Mandatory Mail Order Requirement. Maintenance-type medications can be filled up to a maximum of two times at a participating retail pharmacy, then they must be submitted through the mail order program described below.

Mail Order Pharmacy Benefits

Mail service offers a convenient and less expensive way to fill prescriptions for medications you take for an extended period. You can receive up to a 90-day supply plus refills of maintenance-type medications to treat chronic or long-term conditions (like arthritis, high blood pressure, or diabetes) when you use the mail order service through OptumRx Mail. For more than two 90-day supplies of medications, you must obtain another prescription from your doctor. You may fill the first prescription at a retail pharmacy but thereafter, you must use the mail order pharmacy, or your claim will be denied. You should contact OptumRx for information on how to begin using the mail order pharmacy including how to set up your profile, submit new prescriptions and order refills.

Specialty Drugs

Specialty drugs are available on an outpatient basis only when ordered through and managed by the Prescription Drug Program. Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis, and hepatitis. These drugs require precertification and often require special handling. Contact OptumRx for information on specialty drugs. You can also check their website for information including what drugs are considered specialty drugs.

Medical Management

Pre-certification

Certain prescriptions require precertification in order for it to be covered. Through this program, the Plan will cover these prescription medications under certain clinical protocols managed by the Fund Office. If approved, the medication will be considered for payment under the Plan. When you submit a prescription that requires precertification to the pharmacy, you will be informed by the pharmacist that the prescription requires a letter of medical necessity. In such circumstances, you should contact the Fund Office to discuss. As this list of medications that require prior authorization changes from time to time, you should contact the Fund Office to obtain the most up-to-date information. You must obtain prior authorization by submitting a letter from your doctor explaining the medical necessity for the drug. If you are denied pre-authorization, you have the right to appeal the denial. Your prescription claim will be denied unless you obtain prior approval from the Fund Office.

Step Therapy

In a step therapy program, covered drugs are organized in a series of “steps”. The step therapy program is generally geared towards patients who regularly take prescriptions to treat chronic conditions or who are prescribed a high-cost medication where therapeutically equivalent generic alternatives are available. In order to ensure that the most effective, safe, and cost-conscious prescription is chosen, the Fund has implemented step therapy programs for certain categories of drugs.

In essence, the step therapy program requires you to try generic alternatives prior to the more expensive brand name drug, unless your physician presents an acceptable medical reason for the brand name drug. There are usually two "steps" during which you must select two different generics first.

Since drugs that require step-therapy may change, you are encouraged to contact Optum. Their website (optum.com) is the best source for up-to-date information about all of the medications your pharmacy benefit covers, possible lower-cost options and cost comparisons. In addition, if your physician prescribes a brand name drug on the list, you will be notified at the point of sale that the claim has been denied.

The following prescription drugs are not covered (excluded) by the Plan:

- medications that do not require a prescription/Over the counter (OTC) except insulin and ACA preventive drugs (with a prescription), even if a doctor writes a prescription for the medication; and
- prescription drugs that are considered experimental or investigational or are used off-label, for a reason other than intended.
- **Note:** The Board of Trustees will review this list from time to time, in light of new drugs approved by the FDA and other considerations and revise the list of covered and non-covered drugs and those that require precertification based on criteria established by OptumRx. Please contact OptumRx for the most up-to-date information on which drugs are not covered by the Plan.

Copayment Assistance Program

OptumRx has a copayment assistance program that may help you with the out-of-pocket cost of certain prescription specialty drugs. The program provides discounts when these drugs are dispensed through OptumRx's Specialty Pharmacy. To enroll in these benefits and see if a particular drug qualifies for the copay assistance program, please contact OptumRx.

Prescription Drug Benefits for Medicare Eligible Participants

Medicare covers prescription drug benefits under Part D. If you, as an Active Participant (see Eligibility section for definition of Active Participant), and/or your Eligible Dependent(s) are enrolled in either Part A or B of Medicare, you are eligible for Medicare Part D. For Active Participants and their Eligible Dependents who are Medicare-eligible, this Plan offers "Creditable Coverage." This means that this Plan's prescription drug benefits are expected to pay out, on average, as much or more as the standard Medicare prescription drug benefits will pay. Since this Plan's coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan while you have this Plan's prescription drug coverage as an Eligible Participant in order to avoid a late penalty under Medicare. When you lose coverage under this Plan, you may enroll in a Medicare Prescription Drug Plan either during a special enrollment period or during Medicare's annual enrollment period (October 7 – December 15 of each year). For more information about Creditable Coverage see the Plan's Notice of Creditable Coverage that will be mailed to you from the Plan once a year. You may request another copy of this Notice by calling the Fund Office and asking for one. Please note that this only applies to Active Participants. Once you retire, you will no longer have creditable coverage.

ACA-Preventive Medications and Supplies

The Affordable Care Act (ACA) makes certain preventive medications available to you at no cost. Preventive medications are covered 100% for generic prescription drugs and brand name drugs if a generic is unavailable or medically inappropriate. A list of medications that are covered under this provision are listed below. Coverage of any preventive medications (including over the counter (OTC) medications) requires a prescription from a licensed health care Provider. The list of covered medications is subject to change as ACA guidelines are updated or modified. For the most up-to-date information or more information about which preventative prescription drugs are covered at 100%, please contact OptumRx.

- Aspirin to prevent cardiovascular disease when prescribed by a health care Provider. A prescription must be submitted in accordance with Plan rules.
- Low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia. A prescription must be submitted in accordance with Plan rules.
- FDA-approved contraceptive methods for women, including barrier methods, hormonal methods and implanted devices, as prescribed by a health care Provider. The Plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The Plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care Provider.
- Folic Acid supplements for women who are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid. Over-the-counter supplements are covered only with a prescription.
- Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.
- Application of fluoride varnish to the primary teeth of all infants and children up to age 5 starting at the age of primary tooth eruption, in primary care practices.
- All FDA-approved tobacco cessation medications (including both prescription and over- the-counter medications) for a 90-day treatment regimen when prescribed by a health care Provider without prior authorization. Over-the-counter medications are covered only with a prescription.
- Bowel Preps in connection with a screening colonoscopy. Over-the-counter medications are covered only with a prescription.
- Vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years and older who are at increased risk for falls. Over-the-counter supplements are covered only with a prescription.
- Risk-reducing medications (such as tamoxifen or raloxifene) for women at increased risk for breast cancer and at a low risk for adverse medication effects.
- Low-to-moderate-dose statin for the prevention of cardiovascular disease (CVD) events and mortality in adults ages 40-75 years with one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking), and a calculated 10-year risk of a cardiovascular event of 10% or greater, when identified as meeting these factors by their treating physician.
- ACA-required vaccines. These are generally covered under the Medical Benefits; see the Medical section of this SPD for details. In addition, you may contact OptumRx for information on benefits under the Prescription benefit.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

The Local 15 Welfare Fund administers a Health Reimbursement Arrangement ("HRA") on a self-insured basis, which is designed to provide reimbursement for eligible expenses on a nontaxable basis. You are only eligible to accumulate contributions in the HRA if you are eligible for and enrolled in the Plan. The HRA is intended to qualify as an integrated health reimbursement arrangement under §105 and §106 of the Internal Revenue Code of 1986, as amended, IRS Notice 2015-87 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45 and shall be interpreted to accomplish that objective.

You and your covered Dependents are only eligible for the HRA if you are eligible for and enrolled in the Welfare Fund.

How the HRA Works

Each time you redeem your stamps, you will be credited with the applicable amount according to the Collective Bargaining Agreement in effect at the time of your redemption. The Plan will not create a separate fund or otherwise segregate assets for purposes of paying an HRA benefit. These benefits are not vested.

The amount available to you at any time for reimbursement of qualified medical expenses is the balance in your account. Any unused balance in your account carries over from Benefit Period to Benefit Period. Nothing herein will be construed to require the Plan to maintain any trust fund or to segregate any amount for the benefit of any Participant, and no Participant or other person will have any claim against, right to, security or other interest in any fund, account, or asset of the Plan from which any payment under the HRA may be made.

Integration Rule

Source of Contributions: Your HRA is funded with employer contributions only. You may not contribute to your own HRA. Under no circumstances will the benefits of the HRA be funded with salary reduction contributions, employer flex credit contributions or otherwise under a cafeteria plan.

Eligible Medical Care Expenses. Your HRA can be used for reimbursement of Medical Care Expenses that might not be covered under the Plan. "Medical Care Expenses" means expenses incurred by a participant or his/her Dependents for medical care, as defined in IRS Code §105 and § 213(d) (including, for example, amounts for certain bills for hospital care, doctors or dental care that are not covered under your basic health plan coverage). Some examples of eligible expenses include (but are not limited to):

- deductibles, copayments or coinsurance;
- medical or prescription drug expenses that exceed the Allowed Amount or Plan maximums; and

- expenses (or portion of expenses) that are not covered by the Medical or Prescription Drug benefits.
- **Note:** To be considered an "Eligible Medical Care Expense" that qualifies for reimbursement, an expense must:
    - be incurred and claimed while you are eligible for reimbursement in accordance with all provisions of the Plan;
    - be substantiated by filing a written claim with the Fund Office and providing evidence that an Eligible Medical Care Expense was incurred;
    - not be reimbursable from any other health plan or insurance; and
    - be incurred by you and/or your Dependents for "medical care," as defined in IRS Code §§ 105 and 213(d) as outlined in IRS Publication 502.

For a complete list of covered expenses, you should contact the Fund Office for a copy of the Claim Form which includes a list of eligible expenses.

How to Claim Benefits under the HRA

Only a written request to the Fund Office for reimbursement of an Eligible Medical Care Expense under the HRA is considered to be a claim. In order to be reimbursed, you must submit a signed HRA claim form (along with other documents as described below) to the Fund Office. You must also submit information about your claim, as follows, in order to receive a reimbursement for the HRA:

- completed and signed claim form that describes the person or persons on whose behalf expenses have been incurred, a description of the expense incurred, the date the expense was incurred and the amount of the requested reimbursement; and
- a written statement from the Participant that the expense has not been reimbursed and is not reimbursable under any other source; with either:
    - a copy of the Explanation of Benefits (EOB) for the expenses you are requesting reimbursement for; or
    - an itemized bills, invoices, or other statements from an independent third party (e.g., physician or other health care provider) showing that the Medical Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Fund Office may request.

No reimbursement of Eligible Health Care Expenses will be made if such expenses have been reimbursed by any other health care insurance, plan, provider or entity. If only a portion of an expense has been reimbursed elsewhere (e.g., because the other plan imposes copayments or deductibles), the special benefit can reimburse the remaining portion of such expense if it otherwise meets the requirements herein. Reimbursements are payable only to you, the Participant, not to an insurance company, medical provider or dependent.

Claims can be submitted at any time after an expense is incurred provided you have an account balance.

Reimbursements after Termination and Death. You may continue to receive reimbursements for Eligible Health Care Expenses through the HRA which are incurred after your coverage terminates; this includes paying for COBRA premiums. Claims can be reimbursed only if you have an HRA account balance after the date of termination. If you die and do not have any enrolled eligible dependents your account will be forfeited. If you have eligible Dependents, they may continue to spend down any account balance for a period of four years from your date of death as prescribed by IRS guidelines. If the account balance is not exhausted by the end of this four-year period, the remaining balance shall be forfeited.

Opting Out of the HRA: You may permanently opt out of and waive future reimbursements from the HRA once per year by contacting the Fund Office. If you choose this option, you will forfeit your account balance and will no longer receive contributions. If you do opt out, you will not receive any balance held in your account and any additional compensation.

Exclusions – Medical Expenses that are Not Reimbursable under the HRA

The HRA does not pay for any item that does not constitute "medical care" as defined under IRS Code §§ 105 and 213(d). The following expenses are examples of the kinds of expenses that are not reimbursable. This is not intended to be a complete list of all services that are not payable under the HRA, but an example of more common services that are not payable from the HRA.

- Expenses (or portions of expenses) that are reimbursed/reimbursable through this Plan or any other health plan or insurance.
- Expenses incurred before an individual becomes eligible to participate in the HRA or after an individual's eligibility terminates, except as otherwise specified herein.
- Expenses in excess of the unused amount in your HRA account.
- Long-term care (LTC) services.
- Funeral and burial expenses.
- Custodial care.
- Babysitting and childcare expenses.
- Health club or fitness program dues.
- Social activities, such as dance lessons and swimming lessons to improve general health.
- Household and domestic help (even if recommended by a qualified physician due to an Eligible Retiree's inability to perform physical housework).
- Cosmetics, toiletries, toothpaste, or similar items for personal use.
- Cosmetic surgery
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses except in certain circumstances where transportation is necessary to receive medical care.

- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Premiums paid through salary reduction contributions under the terms of IRS Code § 125 plan or any plan that provides for premium payment with pre-tax dollars.

DENTAL BENEFITS

The Plan provides self-insured dental benefits to you and your eligible dependents. These benefits are administered by the Fund Office. Dental benefits are treated as a stand-alone (or excepted) benefit under the Health Insurance Portability and Accountability Act and the Patient Protection and Affordable Care Act because they may be waived by contacting the Fund Office. No additional compensation is available if dental benefits are waived.

Covered Dental Services

Dental benefits for services performed by a licensed dentist will be paid in accordance with the Plan's schedule of dental care benefits.

Dental benefits will be paid at 100% of the fee schedule to a maximum of $2,000 per person, per calendar year.

The dental benefits will be paid in accordance with the Schedule of Dental Care Benefits listed below, for services performed by a licensed dentist. No benefit will be paid in excess of the amount charged, nor will a licensed dentist be paid for any benefit if the patient does not incur an actual charge. No payment will be made for any amounts for which you are not legally liable in the absence of coverage by the Plan.

Coverage for a dental condition that existed prior to becoming eligible for this benefit will be provided, but no payment will be made for any dental work performed prior to your becoming eligible for this benefit.

No payment will be made for accidents or illnesses covered by Worker's Compensation legislation, nor for treatment received in hospitals, clinics, etc., operated by Federal, State, County or Municipal agencies.

Schedule of Dental Care Benefits

The following benefits are the only benefits that the Plan pays for:

TREATMENT	MAXIMUM ALLOWANCE
PREVENTIVE	
Examination **Two exams allowed per calendar year**	Up to $50 per Exam
X-ray **Four X-rays allowed per calendar year**	Up to $50 toward each set of X-rays
Semi-annual cleaning or scaling of teeth	Up to $80
FILLING **(silver, amalgam, synthetic, acrylics) per tooth**	
Single surface	Up to $56

TREATMENT	MAXIMUM ALLOWANCE
Two surfaces	Up to $76
Three surfaces	Up to $96
Four surfaces	Up to $96
Extractions, each tooth	Up to $75
Root canal, each canal	Up to $250
Periodontal root planning and scaling, each quadrant	Up to $50 twice a year
Periodontal maintenance once per calendar year	Up to $100
Porcelain/gold inlays, each tooth	Up to $175
Porcelain veneer laminate	Up to $76
Post and Core	Up to $150
Caps, crowns, jackets, each tooth	Up to $440
Child's crowns	Up to $190
DENTURES	
Partial dentures	Up to $440 each tooth, up to $1,320 maximum per jaw
Full upper or lower	Up to $500 each denture, once every two years
Reline and addition of new material to tooth	Up to $100 each procedure
Repair and/or replacement of teeth	Up to $90 each tooth, maximum three teeth per repair
ORAL SURGERY	
Complete extractions (where flap repair or sutures are required)	Up to $100 per tooth
Impaction (tooth embedded in jawbone)	Soft tissue up to $250Hard Tissue up to $350
Gingivectomy/osseous surgery	Up to $250 per quadrant
Removal of cysts, including tooth removal	Up to $120
Trimming of bone, each jaw	Up to $120
Anesthesia — for oral surgery only	Up to $150
Incision and drainage of abscess	Up to $120
Removal of root tip, (root apicoectomy) each tip	Up to $180

Orthodontia Benefits

The Plan provides a lifetime allowance of $4,250 toward each dependent child's orthodontia treatment. Provider charges will be subtracted from this allowance as claims are presented. The orthodontia benefit cannot be combined with another benefit available under this Plan to create a larger benefit.

The Fund will allow a $4,250 lifetime allowance towards Participant's and/or an eligible spouse's orthodontia treatment and implant benefit combined. Provider charges will be subtracted from this allowance as claims are presented.

The Participant/Spouse implant/orthodontia benefit cannot be combined with another Participant's benefit to create a larger benefit.

Dental Plan Exclusions and Limitations

- Procedures not listed or not combined within the aforementioned list, and/or fees that exceed the allowance disclosed previously are not covered and will be the responsibility of the participant.
- No benefits will be paid in excess of the amount charged, nor will a licensed dentist be paid for any benefit if the patient does not incur an actual charge.
- No payment will be made for any amounts for which you are not legally liable in the absence of coverage by this Plan.
- No payment will be made for accidents or illnesses covered by Workers' Compensation, nor for treatment received in hospitals, clinics, etc., operated by federal, state, county, or municipal agencies.
- Fluoride treatments and sealants are not covered by this Plan unless as required by the ACA.
- Treatment provided by a relative/family member is not covered.
- Dental Implants for dependent children.

How to File a Claim for Dental Benefits

An ADA claim form must be completed and returned to the Fund Office within 30 days after all dental work is finished.

VISION BENEFITS

The Plan provides self-insured vision benefits to you and your eligible dependents. These benefits are administered by the Fund Office. Vision benefits are treated as a stand-alone (or excepted) benefit under the Health Insurance Portability and Accountability Act and the Patient Protection and Affordable Care Act because they may be declined. (See the Enrollment section of this SPD for details.)

The vision benefit allowance covers charges for an eye examination, contact lenses and/or eyeglasses (lenses and frames) if an optometrist or an optician dispenses the eyeglasses. A maximum allowance up to the amounts shown below will be paid once every calendar year for each Participant.

BENEFIT	REIMBURSEMENT AMOUNT
Examination by an optician or optometrist	$20
Single vision lenses	$50
Bifocal lenses	$60
Trifocal lenses	$75
Contact lenses	$75
Frames	$25

The combined maximum allowable for all lenses is $75 per calendar year. There is no annual deductible associated with this vision benefit. If an ophthalmologist (MD) performs the exam for a medical diagnosis, the Plan will pay in accordance with the Medical Benefit outlined in this SPD.

Covered Vision Expenses

Since the Plan covers eligible expenses only up to a set amount, it is to your benefit to shop for the most cost-effective services and materials. Many vision providers offer coupons for free exams if you purchase a set of lenses and frames; others run seasonal sales. Additionally, the Plan has established relationships with CPS Optical, General Vision Services and Vision Screening which include opticians and optical providers in the metropolitan New York area. CPS Optical, General Vision Services and Vision Screening locations usually provide exams and glasses/contact lenses with no out-of-pocket cost to you. For a listing of these providers and the enhanced benefits, please contact the Fund Office at 212-255-7657 or visit the Plan's website for more information at iuoelocal15.org.

Exclusions and Limitations

You should be aware that some items of vision care are not covered by the Plan. In addition to any item listed in the exclusions and limitations section of the summary plan description, vision benefits are not paid for the following expenses:

- Services, including:
  - eye exams required by an employer;
  - eye exercises, including remedial reading exercises;
  - orthoptics or visual training;
  - refractions; and
  - services/supplies furnished by other than an Optician, Optometrist, or Ophthalmologist.
- Supplies, including:
  - aniseikonic lenses (for binocular vision);
  - non-prescription lenses; and
  - non-prescription sunglasses.
- Treatment, care, services, or supplies incurred after eligibility for coverage ceases, except when lenses and frames are ordered before coverage ends will be covered if they are delivered within 31 days.

How to File a Claim for Vision Benefits

For information on how to file claims and appeals rights, please see the Claims and Appeals section of this SPD.

HEARING AID BENEFIT

Regrettably, loss of hearing is one of the hazards of working within our industry. Few Participants are aware that hearing loss is generally compensable under your employer's workers' compensation policy. Provided you can establish proof that your hearing loss was work related, you may be entitled to receive a monthly stipend from the employer's workers' compensation insurance company for the rest of your life.

In order to establish proof, each Participant should have his or her hearing checked during his or her annual physical. Doing so establishes a "baseline" to which future tests can be compared and will establish proof in order to receive a monthly compensation stipend from your workers' compensation insurance company.

If your employer's workers' compensation insurance company is contesting your hearing loss claim, you may obtain a hearing aid through this Fund and be subject to its subrogation provision up to the limits set forth directly below.

The Fund will allow $2,000 per ear, per participant, once every five calendar years for non-work related hearing loss. Fitting, repair and replacement batteries for hearing aids are not covered.

While you may go to any hearing center you like, the Fund has established a relationship with General Hearing Services. As such, the Welfare Fund has been able to enhance the aforementioned benefits in a manner that can reduce your out-of-pocket cost. For a listing of the provider locations, please call the Fund Office or visit the Fund online at iuoelocal15.org.

When at a participating center, you should present your group name and account number (6083H) to receive the following benefits:

- comprehensive hearing screening; and
- covered hearing services from the Hearing Schedule Exhibit below (you will pay the balance for any hearing device above the $2,000 per year allowance).

HEARING AID	DEVICE PRICE (PER EAR)	AVERAGE MEMBER COST (PER EAR)
Basic (Silver)	$495	$0
Reserve (Gold)	$949	$0
Essential	$1,099	$0
Standard	$1,399	$0
Advanced	$1,899	$0
Premium	$2,399	$399

DEATH BENEFIT

How the Death Benefit Works

You are eligible for the Death Benefit while you are still working in Covered Employment and receiving active benefits. The death benefit is payable to your beneficiary.

In the event that you are eligible for active benefits under this Plan at the time of your death, your designated beneficiary will receive a death benefit of $35,000 should you die either on or off the job. In the event your death is the result of an accident (either on or off the job), your designated beneficiary will receive a death benefit in the amount of $70,000. The Death Benefit is a taxable benefit for which your beneficiary will receive an IRS Form 1099 at the end of the year.

Naming a Beneficiary

You may designate one or more beneficiaries by completing a beneficiary designation form and submitting it to the Fund Office. You can change your beneficiary or beneficiaries at any time by filling out a new form. The change becomes effective when the Fund Office receives a completed Change of Beneficiary Form with your new designated beneficiaries. The beneficiaries on file at the Fund Office at the time of your death will receive the proceeds of the Death Benefit in equal amounts unless you have designated otherwise. If you die without naming a beneficiary or all of your designated beneficiaries die before you, the Death Benefit will be paid to your surviving spouse or your estate (if there is no surviving spouse).

The Plan does not pay benefits to a designated beneficiary who is involved in any way with the death of the Participant.

When Coverage Ends

An active Participant's Death Benefit ends once he or she is no longer working in Covered Employment and/or no longer covered under the Local 15 Welfare Fund.

Pensioners who have retired with active coverage maintain the Death Benefit coverage for life (provided the benefit exists). Note that this benefit is not vested.

The Death Benefit also ends immediately upon the commencement of work by an active participant or pensioner for an employer who is not required to contribute to this Plan on his or her behalf in a category of employment that would otherwise be considered Covered Employment under the terms of this Plan.

Filing a Claim for the Death Benefit

Your designated beneficiary must notify the Fund Office of your death. The Fund Office will then send your beneficiary an application that must be completed, signed and returned to the Fund Office along with a copy of the death certificate, a copy of the completed application, W9 form and social security card or tax ID number as applicable.

What's Not Covered

The Death Benefit is not payable if your loss is caused directly or indirectly, in whole or in part, by any of the following:

- Suicide or self-inflicted injury.
- Overdose under the influence of illicit drugs unless affirmed as accidental in the Death Certificate.
- Death or dismemberment that is not directly caused by an accidental injury.
- Non-commercial air travel.
- While you are working for an employer who is not required to contribute to this Plan on your behalf in a category of employment that would otherwise be considered Covered Employment under the terms of this Plan.
- Death as a result of committing a felony.
- Act of war or an internal conflict, insurrection or rebellion of any country.
- Participants who are on COBRA Continuation Coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Your AD&D Benefit coverage is shown in the following "Summary of AD&D Benefits" chart. Benefits are payable to your beneficiary if you die, or to you if you are severely injured in an accident (except those specifically excluded). The AD&D Benefit is payable in addition to any other coverage you may have.

Summary of AD&D Benefits

LOSS	BENEFIT PAYABLE
Life	$70,000
Both hands at or above the wrist; both feet at or above the ankle; eyesight in both eyes; or any combination of hand, foot and eyesight	$10,000
1 hand at or above the wrist; 1 foot at or above the ankle; or eyesight in 1 eye	$5,000
Thumb or index finger of either hand	$2,500

Loss of a hand or foot means the actual and complete severance through or above the wrist or ankle joint. Loss of eyesight means the irrevocable and complete loss of sight.

Only 1 amount—the largest to which the individual is entitled—will be paid for all losses resulting from a single accident. The loss must take place within 90 days after an accident in order for the AD&D Benefit to be payable.

What's Not Covered

The AD&D Benefit is not payable if your loss is caused directly or indirectly, in whole or in part, by any of the following:

- Suicide or self-inflicted injury.
- Overdose under the influence of illicit drugs.
- Death or dismemberment that is not directly caused by an accidental injury.
- Non-commercial air travel.
- While you are working for an employer who is not required to contribute to this Plan on your behalf in a category of employment that would otherwise be considered Covered Employment under the terms of this Plan.
- Death as a result of committing a felony.
- Act of war or an internal conflict, insurrection, or rebellion of any country.
- Participants who are on COBRA Continuation Coverage.

WEEKLY LOSS OF TIME BENEFIT

The Fund provides a Weekly Loss of Time Benefit (i.e., Short Term Disability benefits) for active participants only. Dependent children and spouses are not eligible for these benefits.

These benefits provide up to 26 weeks of income for active participants who are unable to work due to a non-work-related injury or illness (including disability due to pregnancy). Benefits are not paid for injuries or illnesses arising out of or in the course of your employment. These benefits are guaranteed to be at least the same amount and duration as those payable under New Jersey and New York disability laws. These benefits are insured. Following is a brief summary of the provisions of the benefit.

The amount of disability benefits is 66-2/3rd percent of the weekly maximum wage up to a maximum of $667 if you are employed in New York. For those employees working in New Jersey, this amount will be adjusted annually in accordance with New Jersey Temporary Disability Benefits Law.

Benefits are payable if you become totally unable to perform the duties of your employment as a result of non-occupational accidental injuries or a sickness not compensable under the Workers' Compensation Law that prevents you from performing the duties pertaining to your employment. Weekly Loss of Time benefits are payable from the first day of disability due to an accident and from the 8th day of disability due to sickness. Successive periods of disability separated by a period of not more than 14 days will be considered one continuous period of disability unless they are from a different and unrelated cause.

These benefits are insured and payable in accordance with New Jersey and New York disability laws.

Exclusions

No benefits are payable under for:

- for more than 26 weeks for any one period of disability;
- for any period of disability which did not commence while the claimant was a covered individual;
- for any period during which the claimant is not under the care of a legally licensed physician, dentist, optometrist, podiatrist, practicing psychologist, advanced practical nurse, or chiropractor, who when requested by ULLICO (or any future carrier retained by the Fund to administer this benefit), shall certify within the scope of the practitioner's practice the disability of the claimant, the probable duration thereof, and, where applicable, the medical facts within the practitioner's knowledge;
- due to intentional self -inflicted injury;
- sustained during the insured’s participation in a crime of the first, second, third or fourth degree;
- for any period during which the claimant performs any work for remuneration or profit;

- in a weekly amount which together with any remuneration the claimant continues to receive from the employer would exceed regular weekly wages immediately prior to disability;
- for any period during which an insured would not be eligible for unemployment compensation benefits for gross misconduct;
- any period during which benefits are paid, or payable, under any unemployment compensation law, or any disability or cash sickness benefit, or any similar law; and
- any period during which benefits, other than benefits for permanent partial or permanent total disability previously incurred, are payable due to disability under any workers' compensation law; occupational disease law, or similar law, unless the insured's claim for temporary disability benefits is contested and delayed; and the insured is eligible for disability benefits. In such a case, the insured will be paid temporary disability benefits, until, and unless, the insured receives compensation under any workers' compensation law, occupational disease law, or similar law. Benefits will be subject to the Plan's subrogation rules if settlement from a third party.

A Weekly Loss of Time (Short Term Disability) Claim is a request for benefits during a period of disability. Weekly Loss of Time (Short Term Disability) Claims are filed after a participant suffers a disability and benefits are paid if the Claims Administrator determines that the participant has suffered a disability as defined by the terms of the Plan. Claims should be sent to the Fund Office, and they will be forwarded to the insurance company for processing.

This is not a full description of the Weekly Loss of Time (Short Term Disability) benefits and should only be viewed as a brief summary to assist you in understanding the benefit program. A detailed benefits description, including limitations and exclusions, and claims and appeals, is contained within the Certificate of Insurance, a copy of which may be obtained from ULLICO (or any future carrier retained by the Fund to administer this benefit). The terms, conditions, limits, and exclusions shown in the Certificate of Insurance shall govern.

CLAIMS AND APPEALS

Internal Claims and Appeal Procedures

This section describes the procedures followed by the Welfare Fund in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for medical, Health Reimbursement Arrangement (HRA), dental, vision, prescription drug, and death and accidental death benefits. For information on claims and appeals that pertain to insured Weekly Loss of Time (Short Term Disability) and Paid Family Leave, see the applicable section within the ULLICO Certificate of Insurance.

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review so that Plan provisions are applied consistently with respect to you and other similarly situated participants and dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination (an appeal of a denied claim) that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate or is Experimental or Investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

For medical and prescription drug benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

General Information

Claims Administrator(s)

The Plan Administrator has delegated responsibility for initial claims decisions to the following organizations (See the Contact Information at the beginning of this document):

Appropriate Claims Administrator	Types of Claims Processed
Claims Administrator for PPO In-Network and Out-of-Network Benefits	Initial Claims determinations for Urgent, Concurrent and Pre-service and Post-Services for In-Network Medical Claims
Anthem Blue Cross Blue Shield	Initial Claims determination for Urgent, Concurrent and Pre-service Claims for Out-of-Network Medical Claims

Appropriate Claims Administrator	Types of Claims Processed
Claims Administrator for Vision Claims, HRA and Dental Claims and Death Benefits **I.U.O.E. Local 15 Welfare Fund Office**	Post Service Claims Determinations for HRA and Dental Claims Initial Determination of Death Benefits
Pharmacy Benefits Manager for Prescription Drug Benefits **OptumRx**	The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale is not considered a claim under these procedures. However, if your request for a prescription is denied in whole or in part, you may file a claim or appeal with the Fund Office. Initial Claims Determination for Urgent, Concurrent and Pre-Service Claims for Prescription drugs and Post-Service clams for Non-Participating Pharmacy claims
Vision Benefits Administrator/PPO **General Vision Services (GVS)** **Vision Screening** **CPS Optical**	Participating Providers A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision Provider(s). After the denial by the vision service Provider, you may file a claim or appeal with the Fund Office.
Weekly Loss of Time (Short Term Disability), New York Paid Family Leave **Union Labor Life Insurance Company (ULLICO)** **Send initial claims to the Fund Office and they will be forwarded to ULLICO for payment.**	Initial Claims for Weekly Accident and Sickness (Short Term Disability) Initial Claims for New York Paid Family Leave

Days Defined

For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, other Plan fiduciaries, Claims Administrators, and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to (1) interpret the terms of the Plan; (2) interpret any facts relevant to the determination; and (3) determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, means:

- a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;
- a reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or
- a rescission of coverage, whether or not there is an adverse effect on any particular benefit.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Definition of a Claim

A claim is a request for a Plan benefit made by you or your covered dependent (also referred to as "claimant") or your authorized representative in accordance with the Plan's reasonable claims procedures.

Types of Claims

Health Benefit Claims

Health benefit claims can be filed for medical, HRA, prescription drug, dental and vision benefits. There are four categories of health claims as described below:

- **Pre-Service Claims** – A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained.
- **Urgent Care Claims** – An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (ii) in the opinion of the claimant's attending health care Provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.
- **Concurrent Claims** – A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

- **Post-Service Claims** – A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Death or Accidental Death Claims

A Death or Accidental Death Benefit Claim is a request by a designated beneficiary for benefit payment following the death of the Participant.

Dismemberment Benefit Claims

A claim for Dismemberment Benefit may also be filed by a Participant after he or she has provided the Plan with proof of a bodily loss.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- be written, faxed, or electronically submitted (only applicable for Participating Providers); oral communication is acceptable only for Urgent Care Claims with follow up documentation required;
- be received by an applicable Claims Administrator;
- name a specific individual participant and his/her ID Number;
- name a specific claimant and his/her date of birth;
- name a specific medical/dental condition or symptom;
- provide a description and date of a specific treatment, service or product for which approval or payment is requested; must include an itemized detail of charges and provide specific procedure and diagnostic codes (e.g., CPT codes, ADA Codes, HCPC codes and DSM-10 codes);
- identify the Provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- when another plan is primary payer, include a copy of the other plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is not a claim if it is:

- not made in accordance with the Plan's benefit claims filing procedures described in this section;
- made by someone other than you, your covered dependent or you (or your covered dependent's) authorized representative;
- made by a person who will not identify himself or herself (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;

- a request 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;
- the presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim or appeal with the Plan; or
- a request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision Provider(s). After the denial by the vision service Provider, you may file a claim or appeal with the Plan.

If you submit a claim that is not complete or lacks required supporting documents, the applicable Claims Administrator will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or service that does not require prior approval.

Prohibition on Assignments

The Plan and the Plan Sponsor categorically prohibit and will not accept in any circumstance any assignment or attempt to assign any benefits claims, right to coverage, or any other type of claims, regardless of the nature of such claims and any attempt to do so will be void and will not apply. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person, including the Plan Participant, a Participant's dependent or creditor of the Plan Participant without the express written permission of the Plan Sponsor; however, a Plan Participant may direct that benefits due him/her, be paid to a provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered.

The payment of benefits to a healthcare provider shall be done solely as a convenience and does not constitute an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, is not an assignment of any legal or equitable right to institute any court proceeding against the Plan or the Plan Sponsor, and in no way shall be construed or interpreted as a waiver on the Plan's and Plan Sponsor's prohibition on assignments. The Plan and Plan Sponsor are not responsible for paying healthcare provider invoices that are balance billed to a Plan Participant.

Initial Claim Decision Timeframes

In-Network Claim Filing Deadline

You are generally not required to file a claim form in order to be reimbursed for In-Network/Participating provider benefits because claims will be submitted directly to the appropriate Claims Administrator. If you need to file a claim, they should be filed within 6 months following the date charges were incurred.

Out-of-Network Claim Filing Deadline

Claims for out-of-network benefits should be filed within 12 months following the date charges were incurred. The time period for making a decision on an initial claim request starts as soon as the claim is received provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered dependent, an authorized representative, or by a network Provider.

Health Care Claims – Decision Timeframes

The Plan will provide you, free of charge, with any new or additional information considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such information will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional reason, you will be provided, free of charge, with the reason. The reason will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Pre-Service Claims – Claims for Pre-Service (that are not for Urgent Care) will be decided no later than 15 days after receipt by the appropriate Claims Administrator. You will be notified in writing within the initial 15-day period whether the claim was approved or denied (in whole or in part). The time for deciding the claim may be extended by up to 15 days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written notification before the expiration of the initial 15-day determination period.

If you improperly file a Pre-Service Claim, the Claims Administrator will notify you in writing as soon as possible, but in no event later than five days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, you must re-file a claim to begin the Pre-Service Claim determination process.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing about what specific information is needed before the expiration of the initial 15-day determination period. Thereafter, you will have 45 days following your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Claims Administrator receives your response to the request for information. The Claims Administrator then has 15 days to make a decision and notify you in writing.

Urgent Care Claims – In the case of an Urgent Care Claim, if a healthcare professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Claims Administrator will orally communicate its decision telephonically to you and your health care professional. The determination will also be confirmed in writing no later than 3 days after the oral notification.

If you improperly file an Urgent Care Claim, the Claims Administrator will notify you and your health care professional as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, you must re-file a claim to begin the Urgent Care Claim determination process.

If a claim cannot be processed due to insufficient information, the Claims Administrator will provide you and your health care professional with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, you will have not less than 48 hours following receipt of the notice to supply the additional information. If you do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to you and your health care professional no later than 48 hours after the Claims Administrator receives the specific information or the end or the period given for you to provide this information, whichever is earlier.

Concurrent Claims – If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section. A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section. If the Concurrent Care Claim is approved, you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice. If the Concurrent Care Claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.

Post-Service Claims – Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Administrator. You will be notified in writing within the 30-day initial determination period if the claim is denied (in whole or in part). The time for deciding the claim may be extended by 15 days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

If a claim cannot be processed due to insufficient information, the Claim Administrator will notify you in writing about what information is needed before the expiration of the initial 30-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has 15 days to make a decision and notify you in writing.

Weekly Loss of Time (Short Term Disability) and Paid Family Leave – Decision Timeframes

Pursuant to the ULLICO Certificate of Insurance.

Death and Accidental Death and Dismemberment Benefit – Decision Timeframe

Generally, you will receive written (or electronic, as applicable) notice of a decision on your initial claim within 90 days of receipt of your claim by the Claims Administrator. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Claims Administrator), you will be notified in writing within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

Initial Determinations of Benefit Claims

Notice of Adverse Benefit Determination

If the Claims Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing within the timeframe required to make a decision on a particular type of claim. The notice of Adverse Determination must:

- identify the claim involved (e.g., date of service, health care Provider, claim amount if applicable, denial code and its corresponding meaning) and specific reason(s) for the denial;
- if the denial is based on a Plan standard that was used in denying the claim, a description of such standard;
- give the specific reason(s) for the denial (including a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal or external review);
- if the denial is based on a Plan standard that was used in denying the claim, a description of such standard;
- reference the specific Plan provision(s) on which the denial is based;
- describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

- provide an explanation of the Plan's internal appeal review process along with time limits and information about how to initiate an appeal;
- contain a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal and a right to file an External Appeal;
- if the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that such rule, guideline, protocol or similar criteria that was relied upon will be provided to you free-of-charge upon request;
- if the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request;
- for Urgent Care Claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and
- provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes as well as with the external review process.

Notice of Approval of Pre-Service and Urgent Care Claims

If a Pre-Service claim is approved, you will receive written notice within 15 days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing to you and your health care professional within the applicable timeframe after the Claims Administrator's receipt of the claim.

Internal Appeal Request Deadline

- **Health Care Claims (Applicable to In-Network and Out-of-Network Medical, Health Reimbursement Arrangement (HRA), Prescription Drug, Dental and Vision Benefits)**

  If an initial health care claim is denied (in whole or in part) and you disagree with the Claims Administrator's decision, you may request an internal appeal. You have 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period. Under limited circumstances, explained below in the section on External Review, you may bypass the Plan's internal claims and/or appeal processes and file a request for an external review.

- **Weekly Loss of Time (Short Term Disability) and Paid Family Leave Claims**

  If an initial Weekly Loss of Time (Short Term Disability) Claim is denied and you disagree with the Insurers decision, you may request an internal appeal. All Appeals should be filed with ULLICO and NOT the Fund Office in accordance with ULLICO's Certificate of Insurance.

- **Death and Accidental Death and Dismemberment Insurance Benefit**

  If an initial death or accidental death and dismemberment claim is denied and you disagree with the Plan's decision, you or your beneficiary may request an appeal. You have 60 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an appeal. The Plan will not accept appeal requests filed after this 60-day period.

Internal Appeals Process

Where to File Appeals

In-Network and Out-of-Network Anthem PPO Benefits

Anthem maintains a two-level appeal procedure. Anthem breaks appeals into two categories, Appeals and Grievances, which they define as follows:

- An appeal is a request to review and change an Adverse Determination made when Anthem determines a service is not Medically Necessary or is excluded from coverage because it is considered Experimental or Investigational or if Anthem denies a claim, wholly or partly, for services already rendered, based on their utilization review process.
- A grievance is a verbal or written request for a review of an Adverse Determination concerning an administrative decision not related to medical necessity.

To submit an appeal or grievance, call Participant Services at the telephone number located on the back of your identification card, or write to the applicable address(es) listed below. Please submit any data to support your request and include your Participant identification number and if applicable, claim number and date of service.

Anthem Appeal and Grievance Department
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Health Reimbursement Arrangement (HRA), Prescription Drug, Dental, Vision, and Death Appeals

To file an internal appeal for HRA, Prescription Drug, Dental, Vision, and Death/Accidental Death and Dismemberment Appeals, you must submit a written statement to the Plan at the following address:

Board of Trustees
International Union of Operating Engineers
Local 15 Welfare Fund
44-40 11th Street
Long Island City, New York 11101
Phone: 212-255-7657

Urgent Care appeals may be made orally or in writing.

Appeals Procedures

Your request for an internal appeal must include the specific reason(s) why you believe the initial ***claim denial was improper. You may submit any document that you feel is appropriate to the*** internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will provide you with:

- the opportunity, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to your initial claim for benefits;
- the opportunity to submit to the Plan written comments, documents, records, and other information relating to your initial claim for benefits;
- a full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;
- the Plan will provide you upon request and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;
- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary, or appropriate, the fiduciary or fiduciaries will:
- consult with a healthcare professional who has appropriate experience in the field of medicine involved in the medical judgment; and
    - is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
    - the Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

Health Care Claims

Pre-Service/Concurrent Claims

- **In-Network and Out-of-Network Anthem PPO Medical Benefits Appeals and Grievances**. Anthem maintains a two-level appeal process. Anthem will make the first level determination on the internal appeal or grievance of your initial Pre-Service Claim no later than 15 calendar days from the Plan's receipt of the appeal. You will be sent a written notice of the appeal determination. If you are dissatisfied with the outcome of the Level 1 Appeal or Grievance, a Level 2 Appeal or Grievance may be filed with Anthem within 60 business days from the receipt of the notice of the letter denying the Level 1 Appeal or Grievance. If the appeal is not submitted within that time frame, Anthem will not review it and the decision on the Level 1 appeal will stand. Appeals may be filed by telephone or in writing. A second level appeal determination will be made no later than 15 days from Anthem's receipt of your request for a second level appeal review. No extension of the Plan's internal appeal review timeframes is permitted.
- **Pre-Services Appeals for Prescription and Dental.** A determination will be made and a written notice regarding the appeal will be sent to you within 30 days from the date your written request for an appeal is received by the Plan. No extension of the Plan's internal appeal review time frame is permitted. You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing. A determination will be made on the internal appeal, and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

Urgent Care/Concurrent Claims/Expedited Appeal

- **In-Network and Out-of-Network Anthem PPO Medical Benefits.** Anthem will speed up the appeal process (an "expedited appeal") and deliver a rapid decision when the situation involves:
  - Continuations or extensions of health care services, procedures or treatments already begun;
  - Additional required or provided care during an ongoing course of treatment; or
  - A care in which the Provider believes an immediate appeal is warranted (e.g., the appeal is an Urgent Appeal); or
  - When home health care is requested following discharge from an inpatient Hospital admission

  When requested under these circumstances, the following timeframes will apply:
  - Anthem will provide you or your Provider with a reasonable access to the clinical reviewer within one (1) business day of receiving a request for an expedited appeal. The Provider and clinical peer reviewer may exchange information by telephone, secure email or fax.
  - Anthem will make a decision on an expedited appeal within the lesser of 72 hours of receipt of the appeal request or 2 business days following receipt of all necessary information about the case, but in any event within 72 hours of receipt of the appeal.

- Anthem will notify you and your Provider immediately of the decision by telephone and will transmit a copy of the decision in writing within 24 hours after the decision is made.

If you are not satisfied with the resolution of the expedited appeal, a further appeal may be made through the standard appeal process, as described later in this section, or through an external appeal agent if the appeal is based on Medical Necessity or Experimental or Investigational denials.

If Anthem does not make a decision within 2 business days of receiving all necessary information to review the appeal, Anthem will approve the service.

- **Prescription Drug Appeals.** This is an expedited internal appeals process under which a written notice regarding a decision on the approval or denial of the expedited internal appeal will be sent to you (and your health care professional) no later than within 72 hours of the Plan's receipt of your (oral or written) request for appeal. If your situation involves an urgent medical condition, which the timeframe for completing an expedited internal appeal would seriously jeopardize your ability to regain maximum function, and the claim involves a medical judgment or a rescission of coverage, you may seek an expedited external review at the same time that you request an expedited internal appeal (you must seek both).

Post-Service Claims

- **In-Network and Out-of-Network Anthem PPO Appeals and Grievances.** Anthem who will make the first level determination on the appeal of your initial Post-Service Claim no later than 30 calendar days from their receipt of the appeal request. Anthem will provide a written notice of the determination within 2 business days of reaching a decision. If Anthem does not make a decision within60 calendar days of receiving all necessary information to review your appeal, Anthem will approve the service. If the first level appeal determination results in an adverse benefit determination, you will have 60 calendar days from your receipt of a notice of adverse benefit determination to request a second level appeal review by writing to Anthem. Anthem will then make a second level determination no later than 30 calendar days from its receipt of the second level appeal. You will then be provided with a written (or electronic, as applicable) notification of the second-level appeal determination no later than 30 days after Anthem receipt of your request for a second level appeal.
- **Post Service Appeals for Prescription Drugs, Dental, and HRA Claims.** The Plan will make an appeal determination no later than the date of the Board of Trustees' meeting immediately following the Plan's receipt of your written request for an internal appeal, unless the request for an internal appeal review is filed within 30 calendar days preceding the date of such meeting. In such a case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, an appeal determination will be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary, the Plan will provide you with a written notice of extension describing the special circumstances and date the appeal determination will be made. The Board of Trustees through its designated representative will notify you in writing of the benefit determination no later than 5 calendar days after the benefit determination is made.

Death and Accidental Death Benefit Claims

A written notice regarding a determination of your appeal will be sent to you within 60 days from the date your written request for an appeal is received by the Plan.

Notice of Adverse Benefit Determination Upon Appeal

A written notice of the appeal determination must be provided to you that includes:

- the specific reason(s) for the adverse benefit determination upon appeal, including (i) the reason for the denial (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- reference the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
- a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- an explanation of the external review process, along with any time limits and information about how to initiate a request for an external review;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement must be provided that such 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), a statement must be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge, upon request;
- if the denial was based on a medical judgment (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge, upon request; and
- disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. The law also permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly.

In addition, you are not required to exhaust external review before seeking judicial remedy.

No lawsuit may be started more than three years after the end of the year in which services were provided (or, if the claim is for disability benefits, more than 3 years after the start of the disability).

Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Facility of Payment

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator/Board of Trustees, appropriate Claims Administrator nor any other designee of the Plan will be required to see to the application of the money so paid.

EXTERNAL REVIEW OF CLAIMS

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization (IRO). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act. All notices relating to external review will contain a notice about the availability of Spanish language services. Assistance with filing a claim for external review in Spanish is available by calling the customer service number found on your identification card or by calling the Fund Office. Notices relating to external review will be provided in Spanish upon request.

SPANISH (Español): Para obtener asistencia en Español, llamar al número de servicio cliente encontrado en su tarjeta de identificación o llame a la Oficina del Fondo al 212-255-7657.

Claims Eligible for the External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational.
- The adverse benefit determination involves consideration of whether the plan is complying with the surprise billing and cost-sharing protections of the federal No Surprises Act with respect to Emergency Services, Non-Emergency Services provided by a non-network provider at an In-Network facility, and/or Air Ambulance services.
- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible for the External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment, including grievances about allowed amounts payable under the Plan.
- A determination that you or your dependent is not eligible for coverage under the terms of the Plan.
- Claims that are untimely, meaning you did not request review within the 4-month deadline for requesting external review.
- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).

- Claims that relate to benefits other than health care benefits (such as disability benefits, death benefits, and dental/vision benefits that are considered excepted benefits).

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process. Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- if the Plan waives the requirement that you complete its internal claims and appeals process first;
- in an urgent care situation (see "Expedited External Review of An Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy, or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal; and
- if the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

External Review of a Standard (Non-Urgent Care) Claim

Your request for external review of a standard (Non-Urgent Care) claim must be made in writing within 4 months after you receive notice of an adverse benefit determination. Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

For Anthem PPO (In-Network and Out-of-Network) Claims. All requests for External Review for Anthem PPO Claims should be submitted in writing unless Anthem determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are strongly encouraged to submit any additional information that you think is important for review. Such requests should be submitted by you or your authorized representation to: Anthem National Accounts, Attn: Appeals, P.O. Box 5073, Middletown, NY 10940-0973.

For Prescription Drug Claims. All requests for Prescription Drug claims, must be sent in writing to the Fund Office at 44-40 11th Street, Long Island City, New York 11101.

Preliminary Review of a Standard (Non-Urgent Care) Claim by the Plan

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

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

- the adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage;
- you have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed); and
- your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within 1 business day of completing its preliminary review, the Plan will notify you in writing whether:

- your request is complete and eligible for external review;
- your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)); and
- your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the 4-month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

Review of a Standard (Not Urgent Care) Claim By the IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least 3 accredited IROs to provide external review of claims and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review.
- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within 10 business days. The IRO is not required to, but may, accept and consider additional information you submit after the 10-business-day deadline.
- Within 5 business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.
- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within 1 business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within 1 business day. Upon receipt of such notice, the IRO will terminate its external review.

- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care and effectiveness of a covered benefit.
- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care Providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- a general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care Provider, the claim amount (if applicable), and the reason for the previous denial;
- the date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon;
- a statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law;
- a statement that judicial review may be available to you; and
- a statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Expedited External Review of an Urgent Care Claim

You may request an expedited external review in the following situations if:

- You receive an adverse benefit determination regarding your initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal.

- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a Facility.

To begin a request for expedited external review, do the following:

For Anthem PPO (In-Network and Out-of-Network) Benefits. For Pre-Service Anthem PPO claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through Anthem's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile, or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact Anthem at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

For Prescription Drug Claims. All requests for Prescription Drug claims must be sent in writing to the Fund Office at 44-40 11th Street, Long Island City, New York 11101.

Preliminary Review of an Urgent Care Claim by the Plan

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review of an Urgent Care Claim by the IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least 3 accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available, and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim de novo, meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than 72 hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within 48 hours after it is made.

What Happens After the IRO Decision is Made?

- If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
- If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.
- If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA Section 502(a).

OTHER IMPORTANT INFORMATION

Coordination of Benefits

Since it is possible you and/or your dependents may be covered by more than one health care plan, the Plan contains a coordination of benefits (COB) feature. This allows provisions of two or more plans to be considered when determining benefits. You still may receive up to 100% (but not more) of billed charges (or applicable fee schedule or Allowed Amount) covered by at least one of the plans.

If the "other plan" requires that your dependent take some action, i.e., call the "other plan" before a scheduled surgery or Hospital stay, and your dependent fails to do this, which results in a reduction or denial of benefits from the "other plan," this Plan will not reimburse you or your dependent for what the "other plan" failed to pay.

One plan is primary and determines its regular benefits first. The other plan(s) is secondary and determines its benefits after the primary plan. It is possible the other plan(s) may make up the difference in the total allowable expenses – up to the maximum amount payable without the COB feature. If the other plan(s) is the secondary plan, you may or may not be entitled to receive additional benefits from the plan(s) depending on each plan's COB provision. For information about the secondary plan(s) COB provision(s), see that plan's summary plan description.

Effects of Coordination

When coverage under this Plan is secondary to coverage under another plan, the benefits of this Plan will be reduced so that the total benefits paid or provided by the primary plan and this Plan for a claim will not exceed the total allowable expenses. Also, the amount paid or provided under this Plan will not be more than the amount that would otherwise be paid under this Plan if this Plan was primary.

Which Plan Pays First: Order of Benefit Determination Rules

The Overriding Rules

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. **Any group plan that does not have a set of rules would always pay its benefits first.**

When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first, and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

Rule 1: Non-Dependent or Dependent

1. The plan that covers a person other than a dependent, for example, as an employee, retiree, participant, or subscriber is the primary plan that pays first and the Plan that covers the same person as a dependent is the secondary plan that pays second.

2. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee); then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

1. The plan of the parent whose Birthday falls earlier in the calendar year pays first; and the plan of the parent whose Birthday falls later in the calendar year pays second, if the parents are married:

    - The parents are not separated (whether or not they ever have been married); or if both parents have the same Birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.
    - The word "Birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

2. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any plan year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

    If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the plan that covers the parent whose Birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose Birthday falls later in the calendar year pays second. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

    - the plan of the custodial parent pays first;
    - the plan of the spouse of the custodial parent pays second;
    - the plan of the non-custodial parent pays third; and
    - the plan of the spouse of the non-custodial parent pays last.

3. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as described in Rule 5 (the longer/shorter length of coverage) and if length of coverage is the same, then the birthday rule (Rule 2) applies between the dependent child's parents' coverage and the dependent's self or spouse coverage. For example, if a married dependent child on this Plan is also covered as a dependent on the group plan of their spouse, this Plan looks to Rule 5 first and if the 2 plans have the same length of coverage, then this Plan looks to whose birthday is earlier in the year: the participant-parent covering the dependent or the participant-spouse covering the dependent.

Rule 3: Active/Laid-Off or Retired Participant/Member

1. The plan that covers a person either as an active participant, or as that active participant's dependent, pays first; and the plan that covers the same person as a retired employee, or as that laid-off or retired employee's dependent, pays second.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active participant under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

1. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, participant or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, participant, or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active participant under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

1. If none of the 4 previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.
2. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a participant of the group will be used to determine the length of time that person was covered under the plan presently in force.

How Much This Plan Pays When It Is Secondary:

Secondary Liability of this Plan: When this Plan pays second, it will pay 100% of "Allowable Expenses" less whatever payments were actually made by the plan (or plans) that paid first. This Plan will reduce its benefits so that the total benefits paid or provided by all coordinating plans for each claim as it is processed is not more than 100% of total allowable expenses and in no case will this Plan pay more in benefits than it would have paid had it been the plan that paid first.

"Allowable Expense" means a health care service or expense, including Deductibles, Coinsurance or Copayments, which is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- The difference between the cost of a semi-private room in a Hospital or Health Care Facility and a private room unless the patient's stay in a private Hospital room is determined (by the Plan Administrator or it is designee) to be Medically Necessary.
- If the coordinating plans determine benefits on the basis of an Allowed charge amount, any amount in excess of the highest Allowed Charge is not an allowable expense.
- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- If this Plan is secondary and the primary plan determines benefits on the basis of an allowed amount or scheduled amount and the other coordinating plan provides benefits or services on the basis of negotiated fees because the benefits are in-network, this Plan will only pay the applicable cost-sharing.
- When benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

Allowable expenses do not include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

Administration of Coordination of Benefits (COB)

To administer COB, the Plan reserves the right to:

1. exchange information with other plans involved in paying claims;
2. require that you or your Health Care Provider furnish any necessary information;
3. reimburse any plan that made payments this Plan should have made; and/or
4. recover any overpayment from your hospital, physician, dentist, other Health Care Provider, other insurance company, you or your dependent.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan's Administrator, or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment. This provision will only apply for claims submitted within 12 months of the incurred date.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information this Plan needs to apply the COB procedures.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, benefits for services covered by this Plan will be payable by this Plan subject to the applicable COB rules, but only to the extent they would have been payable if this Plan was the primary plan.

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage or does not have coordination of benefits rules, this Plan will not provide any benefits.

Coordination With Government and Other Programs

Medicaid: If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second.

TRICARE: If a dependent is covered by both this Plan and the TRICARE Program that provides health care services to Uniformed Service members, retirees and their families worldwide, this Plan pays first and TRICARE pays second. For a Participant called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this Plan is secondary for active participants of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by this Plan.

Veterans Affairs/Military Medical Facility Services: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical Facility on account of a military service-related illness or injury, benefits are not payable by this Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or Facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by this Plan to the extent those services are Medically Necessary, and the charges are Allowed Charges.

Motor Vehicle No-Fault Coverage Required by Law: In general, the Fund excludes coverage if benefits are available under motor vehicle no fault insurance. If you are covered for medical and/or dental benefits by both this Fund and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Fund pays second. If you are covered for loss of earnings by both this Fund and any motor vehicle no-fault coverage that is required by law, the benefits payable by this Fund on account of disability will be reduced by the benefits available to you for loss of earnings pursuant to the motor vehicle no-fault coverage.

Indian Health Services (IHS): If an individual is covered by both this Plan and Indian Health Services, this Plan pays first, and Indian Health Services pays second.

Other Coverage Provided by State or Federal Law: If an eligible individual under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

About Medicare Coverage

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

Medicare-Eligible Participants Who Retain or Cancel Coverage Under This Plan: If you, your covered spouse or dependent child become covered by Medicare, you may either retain or cancel (opt out of) your coverage under this Plan. If you choose to retain your coverage under this Plan, as long as you remain actively employed, your health care coverage will continue to provide the same benefits. This Plan will pay first and Medicare will pay second.

If you choose to cancel your coverage under this Plan, coverage for your spouse and/or dependent child(ren) will terminate, but they may be entitled to COBRA continuation coverage. Please refer to the COBRA continuation coverage section of this SPD for further information.

Coverage Under This Plan and Medicare When You Are Totally Disabled: Generally, if you become totally disabled and you are entitled to Medicare because of your disability and you are no longer considered "actively employed," Medicare will be primary and will pay first and this Plan will be secondary and pay second. However, if you do remain actively employed and are entitled to Medicare because of a disability, or if an eligible dependent covered under this Plan becomes totally disabled and entitled to Medicare because of a disability, this Plan pays first for you or that dependent and Medicare pays second.

Coverage Under This Plan and Medicare When You Have End-Stage Renal Disease: If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of End-Stage Renal Disease (ESRD), this Plan pays first, and Medicare pays second for 30 months starting the earlier of:

- the month in which Medicare ESRD coverage begins; or
- the first month in which the individual receives a kidney transplant.

On the 31st month after the start of Medicare coverage (after the "coordination period"), Medicare pays first, and this Plan pays second. This Plan will treat someone for whom Medicare would be the primary payer as if the person is enrolled in (and paying any required premiums for) Medicare Parts A and B. In other words, if a person fails to enroll in and maintain Medicare coverage after the 30-month coordination period is completed (for example, fails to enroll in Part B or to pay the required Medicare Part B premiums), this Plan will nonetheless pay Plan-covered benefits as if the individual had Medicare coverage under Parts A and B. As a result, in order to receive the maximum amount of coverage to which you may be entitled under Medicare, you should consider

enrolling in and paying any premiums required for Medicare coverage, including Part B, no later than the end of the 30-month coordination period.

Medicare and COBRA Continuation Coverage: If you are on COBRA continuation coverage and are also entitled to Medicare, Medicare is primary, and this Plan is secondary. Because Medicare is primary in this situation, the same rule that is described directly above applies in this instance.

Coverage Under Medicare for Pensioners and Their Dependents When a Participant Retires and Is Not Actively Working and Covered Under the Retiree Plan as well as Medicare Parts A and B or Part D, Medicare Pays First, and This Plan Pays Second. See the Retiree Benefits Booklet for details on how coordination works in these instances.

How Much This Plan Pays When It Is Secondary to Medicare

Enroll in Medicare

When Covered by Medicare Parts A or B: When an individual is covered by Medicare Parts A and B and this Plan is secondary to Medicare after the continuation period for ESRD or when someone is covered under COBRA continuation coverage, this Plan pays balances after Medicare has made its payment up to the Plan's Fee Schedule/Allowance for particular service or supply. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the charges of the health care provider or what the Plan would usually allow.

Enrolling in Medicare: It is important that you or your eligible dependent visit an office of the Social Security Administration during the three-month period prior to your 65th birthday to learn all about Medicare.

It is important to keep in mind that benefits that are paid by this Plan for Medicare-eligible individuals where Medicare is primary will be reduced by the amounts that are (or could have been) paid under Medicare Parts A and B. When this Plan is secondary to Medicare, this reduction will apply even if the Medicare-eligible individual is NOT enrolled in Medicare Part A and B.

Subrogation and Reimbursement

Although no benefits are payable under the Fund for medical expenses, disability income benefits or any other benefit (except the death benefit) that is included or includable by any claim or lawsuit instituted by a covered participant and/or covered dependent against any third party, the Fund may advance payment on account of Plan benefits subject to its right to be reimbursed by the participant and/or dependent for the full amount of such advance payment if and when there is any recovery from any third party. By accepting such an advance, the covered participant and/or covered dependent agree that the Plan will be subrogated to the covered participant and/or covered dependent's right of recovery from a third party or that third party's insurer for the entire amount advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule.

The right of reimbursement will apply:

- Even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical, disability income or other benefit expenses for which the advance was made.
- Even if the recovery is not sufficient to make the ill or injured participant and/or dependent whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and without any reduction for legal or other expenses incurred by the participant and/ or dependents in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule).
- Even if the recovery was reduced due to the negligence of the covered participant or covered dependent (sometimes referred to as "contributory negligence"), or any other common law defense.

Reimbursement and Subrogation Agreement. The covered participant and/or any covered dependent on whose behalf the advance is made will be required to execute the Plan's subrogation and reimbursement agreement. In the event that the agreement is not executed, the Plan may refuse to make any advance, but if, at its sole discretion, the Plan makes an advance in the absence of an agreement, that advance will not waive, compromise, diminish, release, or otherwise prejudice the Plan's right to subrogation and reimbursement.

Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not an agreement has been executed, the covered Employee and/or covered Dependent(s) each agree:

1. to reimburse the Plan for all amounts paid or payable to the covered Employee and/or covered Dependent(s) or that third party's insurer for the entire amount Advanced;
2. that the Plan has the first right of reimbursement from any judgment or settlement, including priority over any claim for non-medical charges, attorneys' fees or other costs and expenses;
3. to do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement [and/or subrogation] rights;
4. to not assign the right of recovery to any third party without the specific consent of the Plan;
5. to inform the Plan in writing if a covered Employee and/or covered Dependent(s) were injured by a third party and, within 7 days of such injury, provide information to the Plan Administrator;
6. to notify and consult with the Plan Administrator or designee before initiating any legal action or administrative proceeding against a third party alleged to be responsible for the injury or illness that resulted in the Advance, or entering into any settlement agreement with that third party or third party's insurer based on those acts; and
7. to inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

Workers' Compensation

The Welfare Fund is not obligated to pay the medical costs of injuries, illnesses, or accidents that occur on the job or develop through the type of work that you do. By law, injuries and diseases that occur as a result of your employment are covered under the employer's workers' compensation policy, and are therefore excluded from coverage under the Plan.

CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

HIPAA: Use and Disclosure of Protected Health Information

Effective April 14, 2003, a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that self-funded group health plans like the International Union of Operating Engineers Local 15, 15A, 15C, & 15D, AFL-CIO group health plan (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

- The term "Protected Health Information" (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- PHI does not include health information contained in employment records held by a contributing employer who participates in this Fund in its role as an employer, including but not limited to health information on Weekly Loss of Time (Short Term Disability) benefits, work-related illness/injury, sick leave, Family and Medical Leave (FMLA), state Paid leave, and death benefits.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment in the Plan and is also available from the Fund Office and on the website. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

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

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

A. The Plan's Use and Disclosure of PHI: The Plan will use PHI, without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

1. Treatment is the provision, coordination, or management of healthcare and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

2. Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

    a. Determination of eligibility, coverage, cost sharing amounts (e.g., cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;

    b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and

    c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

3. Health Care Operations includes, but is not limited to:

    a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development, or improvement of methods of payment or coverage policies, quality assessment, patient safety activities.

    b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions.

    c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities.

    d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs.

e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

f. Compliance with and preparation of documents required by ERISA, including Form 5500's, Summary Annual Reports, and other documents.

B. When an Authorization Form is Needed: Generally, the Plan will require that you sign a valid authorization form (available from the Fund Office or an Applicable Claims Administrator) in order for the Plan to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI. In addition, the Plan needs an Authorization Form in order to speak with a spouse or adult dependent. Please make sure to revoke the form should you change your mind or get divorced.

C. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. not use or disclose the information other than as permitted or required by the Plan Document or as required by law;

2. ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;

3. not use or disclose the information for employment-related actions and decisions;

4. not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);

5. report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

6. make PHI available to the individual in accordance with the access requirements of HIPAA;

7. make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. make available the information required to provide an accounting of PHI disclosures;

9. make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;

10. if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

11. notify you if a breach of your unsecured protected health information (PHI) occurs.

D. In order to ensure that adequate separation between the Plan and the Board of Trustees is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

1. The Fund Administrator.

2. Staff designated by the Fund Administrator including Welfare Fund staff as delineated in the Plan's Privacy Policies and Procedures.

3. Business Associates under contract to the Plan including but not limited to the PPO/medical claims administrator, preferred provider organization network, utilization management company, Behavioral Health Program, outpatient and prescription drug program.

E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer.

If you are a minor and have concerns about the Plan releasing PHI to your parents or guardian, please contact the Fund Office or applicable Claims Administrator.

F. Effective April 21, 2005, in compliance with HIPAA Security regulations, the Plan Sponsor:

1. has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan;

2. ensures that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures;

3. ensures that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and

4. will report to the Plan any security incident of which it becomes aware concerning electronic PHI.

G. Hybrid Entity: For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self-funded medical, prescription drug benefits, dental, vision, COBRA administration and HRA administration.

Reduction, Delay or Loss of Benefits

There are certain situations under which benefits may be reduced, delayed or lost. Most of these circumstances are spelled out in the previous sections, but your benefits will also be affected if:

- You or your beneficiary do not file a claim for benefits properly or on time.
- You or your beneficiary do not furnish the information required to complete or verify a claim.
- You or your beneficiary do not have your current address on file with the Fund Office.

You should also be aware that Fund benefits are not payable for enrolled dependents who become ineligible due to age or divorce (unless they elect and pay for COBRA benefits as described in the COBRA Continuation Coverage section of this SPD.

If the Local 15 Welfare Fund mistakenly pays a larger benefit that you are not eligible for or pays benefits that were not authorized by the Plan, the Plan may seek any permissible remedy allowed by law to recover benefits paid in error.

Information You or Your Dependents Must Furnish to the Plan

In addition to information, you must furnish in support of any claim for Plan benefits under this Plan, you or your covered dependents must furnish information you or they may have that may affect eligibility for coverage under the Plan.

Failure to give this Plan a timely notice (as noted above) may cause your spouse and/or dependent child(ren) to lose their right to obtain COBRA continuation coverage, or may cause the coverage of a dependent child to end when it otherwise might continue because of a disability, or may cause claims to not be considered for payment until eligibility issues have been resolved, or may result in a Participant's liability to the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the Participant's future medical, dental and vision benefits.

YOUR RIGHTS UNDER ERISA

As a Participant in the Welfare Fund of the International Union of Operating Engineers Local 15, 15A, 15C, & 15D, AFL-CIO you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to the following.

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a "qualifying event." You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misused the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the EBSA, U.S. Department of Labor listed in your telephone directory or the:

National Office:
Division of Technical Assistance and Inquiries Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
(866) 444-3272

For more information about your rights and responsibilities under ERISA, call (866) 444-3272 or visit www.dol.gov/ebsa.

PLAN FACTS

Official Plan Name	Welfare Fund of the International Union of Operating Engineers Local 15, 15A, 15C, & 15D, AFL-CIO	
Employer Identification Number	13-6694320	
Plan Number	001	
Plan Year	January 1st – December 31st	
Board of Trustees/ Plan Administrator	Board of Trustees of the Welfare Fund of the International Union of Operating Engineers Local 15, 15A, 15C & 15D, AFL-CIO 44-40 11th Street Long Island City, New York 11101	
	Employer Trustees William Tyson The General Contractors Association of New York, Inc 60 East 42nd Street, Room 3510 New York, New York 10165 Michael Salgo The Cement League 49 West 45th Street, Suite 900 New York, New York 10036	**Union Trustees** James T. Callahan I.U.O.E. 1125 17th Street, NW Washington, DC 20036 Thomas A. Callahan I.U.O.E. Local 15 44-40 11th Street New York, New York 11101
Fund Administrator	Catherine Chase Welfare Fund of the International Union of Operating Engineers I.U.O.E. Local 15, 15A, 15C & 15D, AFL-CIO 44-40 11th Street Long Island City, New York 11101	

Agent for Service of Legal Process	Legal process may be served on the Plan or on any member of the Board of Trustees at the following address: The Board of Trustees for the Welfare Fund of the International Union of Operating Engineers I.U.O.E. Local 15, 15A, 15C & 15D, AFL-CIO 44-40 11th Street Long Island City, New York 11101
Type of Plan	This Plan is an employee welfare benefit plan that provides medical, prescription drug, dental, vision, Weekly Loss of Time (short-term disability), death, accidental death, and dismemberment (AD&D) benefits. The Fund self-insures and administers vision, dental, Health Reimbursement Arrangement (HRA), and death and AD&D benefits in accordance with the conditions, limitations and exclusions described in this document. In-Network and Out-of-Network Medical and Hospital benefits are self-insured and administered by Anthem Blue Cross Blue Shield in accordance with Anthem Blue Cross Blue Shield's contract terms, conditions, limitations, and exclusions. The prescription drug benefit is self-insured and administered by OptumRx. The vision benefit is self-insured. The vision networks are administered by General Vision Services, CPS Optical and Vision Screening. Out-of-Network benefits are administered by the Fund Office. Weekly Loss of Time (Short Term Disability) and New York Paid Family Leave benefits are insured and administered by the Union Labor Life Insurance Company (ULLICO).
The Plan's Compliance With Federal Law	The Plan is governed by regulations and rulings of the Internal Revenue Service and the Department of Labor and current Federal tax law. The Plan will always be construed to comply with these regulations, rulings, and laws.
Amendment and Termination of the Plan	The Trustees of the Fund have the authority to amend or terminate the Plan at any time and for any reason. You will be notified if the Plan is amended or terminated; however, the change may be effective before a notice is delivered to you. If the Plan is ended, Plan assets will be applied to provide benefits in accordance with the applicable provisions of Federal law.

Your Disclosures to the Plan	If you provide false information to the Plan or commit fraud, you will be required to indemnify and repay the Plan for any losses or damages caused by your false statements or fraudulent actions. (Some examples of fraud include altering a check and knowingly cashing a voided check.) What's more, if the Plan makes payments as a result of false statements or fraudulent actions, the Board of Trustees may elect to pursue the matter by pressing criminal charges.
Plan Administration	Fund assets are accumulated under the provisions of a Trust Agreement and are held in a Trust Fund for the purpose of providing benefits to participants and defraying reasonable administrative expenses. The Fund is administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees. The Fund's assets and reserves are invested by various investment advisors.
The Discretionary Authority of the Board of Trustees	The Board of Trustees governs the Fund in accordance with an Agreement and Declaration of Trust. The Trustees have the sole and absolute discretionary authority to interpret the terms of the Plan, determine benefit eligibility and resolve ambiguities or inconsistencies in the Plan. All determinations and interpretations made by the Board of Trustees and/or its duly authorized designee(s) will be final and binding upon all participants, beneficiaries and any other individuals claiming benefits under the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate/designee, and other Plan fiduciaries, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder. The Board of Trustees has delegated certain administrative and operational functions to the Fund Manager and his/her staff. Most of your day-to-day questions can be answered by the Fund Office staff.

Collective Bargaining Agreements/Employer Contributions	Benefits are provided pursuant to collective bargaining agreements. The Fund receives contributions according to collective bargaining agreements between your employer and Local 15, 15A, 15C, & 15D AFL-CIO. These collective bargaining agreements provide that employers contribute to the Fund on behalf of each covered participant on a specified basis. Certain other employers (such as the Union and Fund Office) may participate in the Plan by signing a participation agreement. To find out whether a particular employer is contributing to the Fund on behalf of participants working under a collective bargaining agreement or a participation agreement and, if so, to which plan of benefits the employer is contributing, contact the Fund Office. You can look at the collective bargaining agreements at the Fund Office or get your own copy upon written request to the Fund Office. The Fund Office will also provide you with, upon written request, a list of Contributing Employers.
No Liability for the Practice of Medicine or Dentistry	The Plan, the Trustees and their designees are not engaged in the practice of medicine or dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care Provider. Neither the Plan, the Trustees, nor any of their designees will have any liability whatsoever for any loss or injury caused to you by any health care Provider by reason of negligence, by failure to provide care or treatment or otherwise.
The Plan's Right to Offset	In the event any payment is made by the Plan to an individual who is not entitled to payment, the Plan shall have the right to reduce future payments payable to such individual by the amount of any erroneous payment. This right of offset, however, shall not limit the right of the Plan to recover overpayments in any other manner.

Facility of Payment	If the Plan Administrator or its designee determines that you cannot submit a claim or proof that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, Claim Administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

DEFINITIONS

There are defined terms used throughout this document. Please note, the list of definitions is not exhaustive, for a full list of definitions, see the Anthem Certificate.

TERM	DEFINITION
Allowable Amount or Maximum Allowable Amount	Please refer to the subsection entitled Maximum Allowed Amount in the Medical Benefits section of this Booklet for a definition.
Ancillary Services	1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; 2. Items and services provided by assistant surgeons, hospitalists, and intensivists; 3. Diagnostic services, including radiology and laboratory services; and 4. Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.
Annual Out-of-Pocket Maximum	The most you pay during a calendar year in cost sharing for In-Network benefits before your Plan begins to pay 100% of the Maximum Allowed Amount for Covered Services. The Annual Out-of-Pocket Limit does not include amounts over the Maximum Allowed Amount, or charges for services that your Plan does not cover. The Annual Out-of-Pocket Limit may consist of Deductibles, Coinsurance and/or Copayments.
Ambulatory Surgery	Surgery performed as an outpatient basis in an accredited hospital or approved surgical center that does not require an overnight stay.
Beneficiary	A person who is designated by you to receive benefits under this Plan. See the Death and Accidental Death Benefits section for details on naming a beneficiary for those benefits.
Calendar Year	Calendar year is January 1 through December 31.
Clean Claim	A clean claim is defined as a complete claim as described in the Claims and Appeal sections that does not require any additional information to process it.
Collective Bargaining Agreement	The contract(s), as amended, between the Union and any employer or any Association covering wages, hours and conditions of employment requiring contributions to this Plan.

Continuing Care Patient	An individual who is: (1) receiving a course of treatment for a "serious and complex condition"; (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the provider or facility.
Copayment	The fee you pay for office visits and certain covered services when you use in-network providers. The plan then pays 100% of remaining covered expenses.
Coinsurance	The percent applied to covered charges (not including Deductibles) for certain Covered Services or supplies in order to calculate benefits under the Plan. These are shown in the Schedule of Medical Benefits. The term does not include Copayments. For example, if the Plan's Coinsurance for an item of expense is 80%, then the covered person's Coinsurance for that item is 20%.
Covered Employment	Work covered by a Collective Bargaining Agreement between your employer and the Union. The collective bargaining agreement requires your employer to contribute to the Plan on your behalf.
Covered Expense or Covered Service	Covered expense or covered service includes expenses covered under the Plan for treatment, care, services, or supplies, but only to the extent that: • they are Medically Necessary; • coverage is not excluded under the Plan; and • no Plan maximums for those expenses have been reached.
Deductible	The dollar amount you and your eligible dependents must pay each calendar year before the Plan pays benefits for Covered Services.
Effective Date	The date on which coverage under a health benefits plan begins.
Emergency Medical Condition	A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: 1. serious impairment to bodily functions; or 2. serious dysfunction of any bodily organ or part; or 3. placing the health of an individual, a woman or her unborn child in serious jeopardy.

Emergency Services	1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and 2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished). 3. Emergency services furnished by an Out-of-Network provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until: a. the provider or facility determines that you are able to travel using nonmedical transportation or nonemergency medical transportation; b. you are supplied with a written notice, as required by federal law, that the provider is an Out-of-Network Provider with respect to the Welfare Fund, of the estimated charges for your treatment and any advance limitations that the Welfare Fund may put on your treatment, of the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and c. you give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.
Employer	Any Employer who contributes, or is required to contribute, to the Fund pursuant to the terms of a Collective Bargaining Agreement or other written agreement.

Essential Health Benefits	For purposes of meeting the Essential Health Benefits requirement of the Affordable Care Act, the Board of Trustees has adopted the Utah benchmark plan, pursuant to federal regulation 45 CFR 156.100. Essential Health Benefits means health benefits as defined under federal and Utah state law to include the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management. For purposes of this Plan, Essential Health Benefits do not include chiropractic, acupuncture, private duty nursing, sleep study, infertility treatment, sclerotherapy and vein therapy, and Lasik surgery.
Explanation of Benefits (EOB)	A statement provided by the Welfare Fund that explains the benefits provided, the allowable reimbursement amounts, any deductibles, coinsurance or other adjustments taken and the net amount paid. A participant typically receives an explanation of benefits with a claim reimbursement check or as confirmation that a claim has been paid directly to the provider.
Fund	The Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C & 15D AFL-CIO.
Gene Therapy	Gene therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems.
Health Care Facility (for non-emergency services)	1. A hospital (as defined in section 1861(e) of the Social Security Act). 2. A hospital outpatient department. 3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act). 4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.
Home Health Care Agency	An organization currently certified or licensed by the State, which can provide home health services.
Hospital/Facility	For purposes of certifying inpatient services, a hospital or facility must be a fully licensed acute-care general facility that has all of the following on its own premises: • A broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies.

	• 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times. • A fully staffed operating room suitable for major surgery, together with anesthesia service and equipment. The hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care. • Assigned emergency personnel and a “crash cart” to treat cardiac arrest and other medical emergencies. • Diagnostic radiology facilities. • A pathology laboratory. • An organized medical staff of licensed doctors. For pregnancy and childbirth services, the definition of “hospital” includes any birthing center that has a participation agreement with either Anthem or another Blue Cross and/or Blue Shield plan. For physical therapy purposes, the definition of a “hospital” may include a rehabilitation facility either approved by Anthem or participating with Anthem or another Blue Cross and/or Blue Shield plan other than specified above. For kidney dialysis treatment, a facility in New York State qualifies for in-network benefits if the facility has an operating certificate issued by the New York State Department of Health and participates with Anthem or another Blue Cross and/or Blue Shield plan. In other states, the facility must participate with another Blue Cross and/or Blue Shield plan and be certified by the state using criteria similar to New York’s. For behavioral healthcare purposes, the definition of “Hospital” may include a Facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a Facility operated by the Office of Mental Health; or a Facility that has a participation agreement with Anthem to provide mental and behavioral healthcare services. For alcohol and/or substance abuse received out-of-network, a Facility in New York State must be certified by the Office of Alcoholism and Substance Abuse Services. A Facility outside of New York State must be approved by the Joint Commission on the Accreditation of Healthcare Organizations. For certain specified benefits, the definition of a “hospital” or “facility” may include a hospital, hospital department or facility that has a special agreement with Anthem.

	The Plan does not recognize the following facilities as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted above); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges, or camps.
In-Network Benefits	Benefits for Covered Services delivered by In-Network Providers and Suppliers. Services provided must fall within the scope of their individual professional licenses.
In-Network Provider/Supplier	A doctor, other professional Provider, or a durable medical equipment, home health care or home infusion supplier who: • is in Anthem's PPO network; • is in the PPO network of another Blue Cross Blue Shield plan; and/or • has a negotiated rate arrangement with another Blue Cross Blue Shield plan that does not have a PPO network.
Itemized Bill	A bill from a provider, hospital, facility or ambulance service that gives information that is needed to settle your claim. Provider and facility/hospital bills will contain the patient's name, diagnosis, and date and charge for each service performed. A provider bill will also have the provider's name and address and descriptions of each service, while a hospital/facility bill will have the Participant's name and address, the patient's date of birth and the Participant's identification number. Ambulance bills will include the patient's full name and address, date and reason for service, total mileage traveled, and charges.
Lien / Subrogation Reimbursement Agreement	An agreement that gives the Fund the right to recover payment for any amount it has paid or will pay arising out of, or relating to, any and all of the rights, claims, causes of action, and interest which you (your spouse or covered children) may have against any person, firm, corporation, insurance company, payer, uninsured motorist fund, no-fault insurance carrier, or other entity in regard to such injuries, expenses or losses.

Medically Necessary	Those services and supplies provided by a Hospital, Physician or other licensed provider of health care services to identify or treat an illness or injury which has been diagnosed or is reasonably suspected, and which are: • appropriate and consistent with a medical diagnosis provided by a legally qualified Physician or surgeon operating within the scope of his or her license; • in accordance with the acceptable standards of community practice; • could not have been omitted without adversely affecting either you or your eligible dependent's condition or quality of medical care. • required for reasons other than your convenience, or that of the Physician or other licensed provider, and • the most appropriate supply or level of service, which can be provided for your safety. The fact that a network provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it medically necessary.
Mental or Nervous Disorder	A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder, if the cause of such condition is not organic or the result of externally induced chemical agents.
Non-Participating Hospital/Facility	A hospital or facility that does not have a participation agreement with Anthem or another Blue Cross and/or Blue Shield plan to provide services to persons covered under Anthem's PPO contract or a hospital or facility that does not accept negotiated rate arrangements as payment in full in a plan area without a PPO network.
No Surprises Services (to the extent covered under the Welfare Fund):	1. Out-of-network Emergency Services; 2. Out-of-network air ambulance services; 3. Non-emergency ancillary services for anesthesiology, pathology, radiology and diagnostics, when performed by an out-of-network provider at an in-network facility; and 4. Other out-of-network non-emergency services performed by an out-of-network provider at an in-network health care facility with respect to which the provider does not comply with federal notice and consent requirements.
Out-of-Pocket	Coinsurance, deductibles, copayments or fees paid by participants for health services or prescriptions. See the Medical and Prescription Drug sections for details on the Plan's Out-of-Pocket Limitation for In-Network services.

Outpatient Surgery	See “same-day surgery.”
Participating Hospital/Facility	A hospital or facility that: • is in Anthem’s network; • is in the PPO network of another Blue Cross and/or Blue Shield plan; and • has a negotiated rate arrangement with another Blue Cross and/or Blue Shield plan that does not have a PPO network.
Plan Administrator	The person who has certain authority concerning the health plans, such as plan management, including deciding questions of eligibility for participation, and/or the administration of plan assets. Anthem is not the Plan Administrator. To identify your Plan Administrator, contact the Board of Trustees.
Pre-certified Services	Services that must be coordinated and approved by Anthem’s Medical Management or Behavioral Healthcare Management Programs to be fully covered by the Plan. Failure to pre-certify may result in a reduction or denial of benefits.
Pretreatment Estimate	Pretreatment Estimate is a predetermination of the benefits payable by the Plan. Predetermination of benefits helps you avoid surprises by letting you and your provider know in advance what services are covered and what payment will be made by the Fund.

Provider	A hospital or other healthcare facility, or other appropriately licensed or certified professional healthcare practitioner including but not limited to a physician, physician assistant or nurse practitioner (who provides healthcare services under the supervision of a physician), registered nurse, and physical therapist. The Plan will pay benefits only for covered services within the scope of the practitioner's license. For behavioral health care purposes, "Provider" includes care from psychiatrists, psychologists or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be licensed by the New York State Education Department or a comparable organization in another state and have 3 years of post-degree supervised experience in psychotherapy and an additional 3 years of post-licensure supervised experience in psychotherapy. For maternity care purposes, "provider" includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed facility and whose services are provided under qualified medical direction. To the extent required by the Patient Protection and Affordable Care Act of 2010, if a service is covered under the Plan, the Plan will not discriminate based on the license or certification of the individual providing the service if: • the individual is licensed to provide such services in the state in which the services are performed; and • the individual is acting within the scope of that license.
Qualifying Payment Amount ("QPA")	The median contracted rates of the plan or issuer for the item or service in the geographic region, calculated in accordance with regulation 29 CFR 716-6(c).
Recognized Amount	1. an amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; 2. an amount determined by a specified state law; or 3. the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount ("QPA"). 4. For air ambulance services furnished by Out-of-Network providers, Recognized Amount is the lesser of the amount billed by the provider or facility or the QPA.

Retiree	A person who is awarded and receiving a pension from the Central Pension Fund of the International Union of Operating Engineers and who meets the conditions for eligibility as set forth in the Plan.
Same-Day Surgery	Same-day, ambulatory or outpatient surgery is surgery that does not require an overnight stay in a Hospital.
Serious and Complex Condition	1. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent; or 2. In the case of a chronic illness or condition, a condition that is the following: a. Life-threatening, degenerative, potentially disabling, or congenital; and b. Requires specialized medical care over a prolonged period of time.
Subrogation	Subrogation means the Welfare Fund's right to recover any payments made because of an injury to you or your dependents caused by a third party's wrongful act or negligence, and which you or your dependents later recover from the third party or the third party's insurer.
Trust Agreement	The Agreement and Declaration of Trust entered into between the Union and Contributing Employers establishing the Welfare Fund of the International Union of Operating Engineers Local 15, 15A, 15C & 15D, AFL-CIO.
Trustees	The Fund Trustees acting pursuant to the Agreement and Declaration of Trust establishing the Fund, and any successor Trustees, duly designated in the manner set forth in the Agreement and Declaration of Trust.
Treatment Maximums	Maximum number of treatments or visits for certain conditions.

WELFARE FUND *of the* INTERNATIONAL UNION OF OPERATING ENGINEERS

LOCAL 15, 15A, 15C & 15D, AFL-CIO

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