A Guide To Your Benefits

Local 138, 138A, 138B & 138C
International Union of Operating Engineers

Welfare Plan

SILVER PLAN

2022

SILVER PLAN

The Trustees have adopted a secondary level of benefits known as "Silver" for individuals who first become eligible for benefits under the Local 138, 138A, 138B & 138C, I.U.O.E. Welfare Fund on or after January 1, 2016. The following plan of benefits will be provided to these members if they satisfy the eligibility requirements under the Plan.

INITIAL ELIGIBILITY REQUIREMENTS

Active Employees. You and your eligible dependents will qualify for health benefits after you accumulate 1,000 hours of covered employment within no more than 12 consecutive months. Initial coverage is established on a quarterly basis. This means your coverage will begin on the January 1, April 1, July 1 or October 1 closest to the date after you first accumulate the necessary hours.

Covered employment. Covered employment means work for which your employer has made contributions to the Welfare Fund, because of his collective bargaining agreement or because he has a participation agreement with the Fund Trustees. Reciprocal time with certain other plans, for which the Welfare Fund receives contributions, will also count as covered employment.

CONTINUING ELIGIBILITY REQUIREMENTS

Active Employees. The Plan uses "qualifying dates" to determine continuing eligibility. This means that after you satisfy the initial eligibility requirements of the Plan, your wage reports will be reviewed periodically to see if you have worked the necessary hours of covered employment to continue your coverage.

The qualifying dates for this Plan occur twice a year, January 1 and July 1. In order to continue your eligibility, you must:

- work at least 200 hours of covered employment during the six consecutive months prior to the qualifying date,

- work at least 1,000 hours of covered employment during the 12 consecutive months prior to the qualifying date, and

- file wage reports. Each month you are required to file wage reports by the 10th of the month following the month worked, whether you work or not. Filing of wage reports allows all the

jointly administered funds to maintain a continuous wage file on your behalf. Wage reports are posted monthly. Failure to file wage reports places your eligibility in jeopardy because benefits cannot be credited to you until wage reports have been submitted for the corresponding period.

TERMINATION OF COVERAGE

Coverage for active participants and their eligible dependents will end at the earliest of the following events:

- the date the Welfare Plan terminates;

- the date the Plan ceases coverage for the class of covered persons for which you belong;

- the last day of the calendar month during which you fail to satisfy the continuing eligibility requirements of the Plan;

- the last day of the calendar month during which your active covered employment with Local 138,138A,138B & 138C Welfare Fund ceases (except as described on the previous page); or

- for dependents, the end of the month your dependent ceases to satisfy the Plan's eligibility requirements for dependents. However, if you die while covered as an active participant, your eligible dependents who are covered at the time of your death will be able to continue their coverage until the sooner of the following:

    - ♦ the end of the period for which you would have been eligible, had you survived;

    - ♦ the date your dependent becomes eligible for other group health benefits or Medicare;

    - ♦ the date your dependent ceases to satisfy the Plan's eligibility requirements for dependents; or

    - ♦ the date the Plan terminates.

Active employees over age 70 ½ who are receiving a pension benefits from the I.U.O.E. Central Pension Plan but have not retired from covered employment must satisfy the eligibility requirements for active employees, as outlined above.

REINSTATEMENT AFTER TERMINATION OF COVERAGE

If your coverage is terminated, you must once again satisfy the initial eligibility requirements to have your coverage reinstated.

DEPENDENT ELIGIBILITY

Eligible dependents are your lawful spouse and your children.

The term "Spouse" shall mean the person recognized as your husband or wife under the laws of the state in which your marriage ceremony occurred. The Fund Administrator may require documentation proving a legal marital relationship. (See Section XVII for the definition of Lawful Spouse for coverage purposes).

The term "Child" shall mean:

- your natural child,
- your adopted child,
- a child placed with a covered participant in anticipation of adoption,
- a step-child who lives in your household and is not eligible for coverage by paternal parent/parents,
- your foster child,
- a child for which you have been appointed legal guardian, and
- your child who is designated as an alternate payee under a Qualified Medical Child Support Order.

The phrase "child placed with a covered participant in anticipation of adoption" refers to a child whom the participant intends to adopt, whether or not the adoption has become final, who has not

attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such participant of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have been commenced.

Your dependent child will be covered up to and including the month they reach age 26. Such coverage will not consider whether the child is "primarily dependent upon" the covered participant for support and maintenance as defined by the Internal Revenue Code and the covered participant declaring the child as an income tax deduction, or whether the child is living in the house of the Participant. Furthermore, this coverage may extend to a married child up to age 26 (coverage excludes the spouse).

If your covered dependent child is totally disabled, coverage may be continued beyond age 26. To be considered totally disabled, your dependent child must be:

- incapable of self-sustaining employment by reason of mental or physical handicap,
- primarily dependent upon you for support and maintenance,
- unmarried,
- covered under the Plan when reaching age 26, and
- not eligible for coverage elsewhere.

The Fund Administrator may require, at reasonable intervals during the two years following the dependent's 26th birthday, subsequent proof of the child's total disability and dependency. After the initial two-year period, the Fund Administrator may require subsequent proof not more than once each year. The Fund Administrator reserves the right to have a disabled dependent examined by a physician of the Fund Administrator's choice, at the Fund's expense, to determine the existence of a total disability.

DEPENDENTS EXCLUDED FROM COVERAGE

The following dependents are excluded from coverage:

- other individuals living in your home but who are not eligible as defined,

- your former spouse (because of divorce or legal separation),
- any person who is on active duty in any military service of any country, or
- any person who is covered under the Plan as an employee.

Participant v. Dependent Status. Under this Plan, you may only be covered as either a Participant or a dependent at any one time. If conditions so warrant, you may change your status from employee to dependent or dependent to employee. Credit will be given for deductibles and all amounts applied to maximums.

If both husband and wife are employees, their eligible dependent children will be covered as dependents of either the husband or the wife but not as dependents of both.

Stepchild Coverage.

To provide coverage for a stepchild, the following requirements must be met.

- The stepchild must be under age 26.
- No one, except the member's spouse, may be required by court order to provide medical coverage for the child.
- The member must complete and submit an application for coverage and must provide any documents requested by the Fund.

ENROLLING FOR COVERAGE

You enroll for coverage by completing the proper enrollment forms, which are available at the Fund Office. It is your responsibility to obtain these enrollment forms. Enrollment forms must also be completed for each eligible dependent (including newborn children) for which you would like to provide coverage. The Fund Office must receive your fully completed enrollment forms and any necessary documentation within 31 days after you or your dependents become eligible for coverage.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or

if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Administrator.

If either of the following two events occur, you will have 60 days from the date of the event to request enrollment in the Fund:

- TERMINATION OF MEDICAID OR CHIP COVERAGE – If you or your dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage under such a plan is terminated as a result of a loss of eligibility.

- ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP – If you or your dependent becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relations to such a plan. In general, this is a program where the state assists employed individuals with premium payment assistance for a group health plan rather than provide direct enrollment in a state Medicaid program.

Special Enrollment Provisions for Newborn Children. A newborn child of a covered person will be covered under the parent's coverage for routine well newborn nursery care as provided for under the Plan. For coverage considered more than routine well newborn nursery care to be covered from the time of the child's birth, the newborn child must be enrolled as a dependent within 31 days following his or her birth.

Late Enrollment. If the Fund Office does not receive the proper enrollment forms and any other necessary documents within 31 days of your eligibility or your dependent's eligibility, enrollment will be considered "late". If enrollment is late, coverage will not begin until you provide the Fund Office with proof of good health for you or your dependent. A health examination may be required as part of this proof. Any cost incurred in obtaining this proof of good health is solely your responsibility.

CONFIRM YOUR ELIGIBILITY!

You should call the Fund Office at the telephone number listed below to verify eligibility for

Plan benefits BEFORE you or your eligible dependents incur any charges.

Fund Office: (631) 694-2480 ext. 2

The Medical Benefits are provided directly through the Welfare Fund. Administering a plan as large as the Local 138 Welfare Plan is complex. Therefore, the Fund has hired a third party administrator to assist the Fund Administrator and his staff with administering the Plan. In addition, the Fund has entered into an agreement with Magnacare, which permits the Plan to offer you access to the Magnacare Network of providers. Benefits are only available for in-network providers only. New Members must verify whether the provider is participating in the MagnaCare network. Services performed by doctors who are determined to be out-of-network will not be covered at all.

BENEFITS PROVIDED UNDER THIS PLAN

Lifetime Maximum. The Plan does not have a lifetime maximum on essential benefits.

Annual Maximum. The Plan does not have an annual maximum on essential benefits

DEFINITIONS

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of physicians, has continuous physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a hospital or in a hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery (no more than 24 hours); provide care under the full-time supervision of a physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Board of Trustees is the governing body of the Plan; half represent the employees and half represent the participating employers.

Calendar Year means January 1 through December 31 of the same year.

Child means your natural child, adopted child, a child placed with a covered participant in anticipation of adoption, a step-child who lives in your household and is not eligible for coverage by paternal/maternal parents, your foster child, a child for which you have been appointed legal guardian; and your child who is designated as an alternate payee under a Qualified Medical Child Support Order.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Co-Insurance Co-insurance is a pre-determined percentage of a covered charge not covered by the Plan. Co-insurance applies toward the maximum out-of-pocket expense.

Co-Payment or Co-pay A co-payment is a small amount of money that is paid each time a particular service is used. Typically, there may be co-payments on some benefits and not on others. Co-payments do not apply toward the maximum out-of-pocket expense and must be paid even after you satisfy the maximum out-of-pocket expense.

Cosmetic Surgery means surgical procedures which are not medically necessary; usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements.

Covered Person is a participant, retiree or dependent who is covered under this Plan, based on eligibility requirements as established by the Board of Trustees of the Local 138, 138A, 138B International Union of Operating Engineers Welfare Fund.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Deductible A deductible is an amount of money that is paid once a calendar year by the covered person before the Plan pays for any covered services. As of January 1 of each year, the deductible must once again be satisfied. Deductibles do not apply toward a maximum out-of-pocket expenses.

Covered expenses incurred in and applied toward your deductible in the months of November and December will be applied toward the deductible in the next calendar year.

If two or more covered members of your family are injured in the same accident, they do not have to meet separate deductibles for treatment of injuries incurred in this accident. Instead, only one deductible for the calendar year in which the accident occurred will be required for them as a unit.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental or Investigational means technology that is either:

1. not of proven benefit for the particular diagnosis or treatment of the covered person, or

2. not generally recognized by the medical community, as reflected in the published peer-reviewed literature, as effective or appropriate for the particular diagnosis or treatment of the covered person's particular condition.

Government approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis of a covered person's particular condition.

The Fund Administrator may, in his discretion, apply any or all of the following criteria in determining whether a technology is experimental or investigational, obsolete or ineffective:

1. Any medical device, drug or biological product must have received **final** approval to market the United States Food and Drug Administration (FDA) for the particular diagnosis or condition.

2. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for **another** diagnosis or condition may require that any or all of these criteria be met.

3. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes.

4. Demonstrated evidence, as reflected in the published peer-reviewed medical literature, must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.

5. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

6. Proof must exist in the published peer-reviewed medical literature that improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects) is possible in standard conditions of medical practice outside clinical investigatory settings.

Family Unit is the covered participant or retiree and the family members who are covered as dependents under the Plan.

Generic Drug means a prescription drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Hospice Unit is a facility or separate hospital unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic

facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of physicians; it continuously provides on the premises 24 hour a day nursing services by or under the supervision of registered nurses; and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of Hospital shall be expanded to include the following:

1. A facility operating legally as a psychiatric hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

2. A facility operating primarily for the treatment of substance abuse if it meets these tests:

    - maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients;

    - has a physician in regular attendance;

    - continuously provides 24 hour a day nursing service by a registered nurse;

    - has a full-time psychiatrist or psychologist on the staff; and

    - is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of substance abuse.

Injury means an accidental physical injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has:

1. facilities for special nursing care not available in regular rooms and wards of the hospital;

2. special life saving equipment which is immediately available at all times;

3. at least two beds for the accommodation of the critically ill; and

4. at least one registered nurse in continuous and constant attendance 24 hours a day.

Spouse shall mean the person recognized as your husband or wife under the laws of the state in which you live. However, the term Lawful Spouse shall not include a spouse who is living separate from a participant pursuant to a written separation agreement.

Lifetime means while covered under this Plan. Under no circumstances does lifetime mean during the lifetime of a person beyond coverage under this Plan.

Maximum Out-Of-Pocket Expense: The Major Medical Benefit covers a predetermined percentage of covered charges until you satisfy the maximum out-of-pocket expense. After the out-of-pocket expense maximum is paid, the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year (unless otherwise stated). The maximum out-of-pocket expense is currently $4,000 per calendar year per covered person for in-network charges and $8,000 per calendar year for family.

The charges for the following do not apply toward the 100% maximum out-of-pocket expense and are not paid at 100% when an out-of-network provider is used, even after the maximum out-of-pocket expense is met:

- deductibles,
- office visit co-payments,
- private day nursing,
- chiropractic care,
- home health care, and
- mental and substance abuse charges.

Medical Care Facility means a hospital, a facility that treats one or more specific ailments or any type of skilled nursing facility.

Medically Necessary Care and Treatment is recommended or approved by a physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a physician recommends or approves certain care does not mean that it is medically necessary.

Mental Disorder means any disease or condition that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the US Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables for a person of the same height, age and mobility as the covered person.

Outpatient Care is treatment including service, supplies and medicines provided and used at a hospital under the direction of a physician to a person not admitted as a registered bed patient; or services rendered in a physician's office, laboratory or x-ray facility, an Ambulatory Surgical Center or the patient's home.

Participant means a person who is covered under the Local 138, 138A, 138B International Union of Operating Engineers Welfare Plan.

Physician means a doctor of medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.) and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Local 138, 138A, 138B, 138C International Union of Operating Engineers Welfare Plan, which is a benefits plan.

Plan Year is the period beginning July 1 and ending June 30.

Prescription Drug means any of the following:

1. a drug or medicine which, under federal law, is required to bear the legend "Caution: federal law prohibits dispensing without prescription;"

2. injectable insulin;

3. hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed physician.

Substance Abuse is the condition caused by regular excessive compulsive drinking of alcohol and/or habitual dependence on drugs that results in a chronic disorder affecting physical health

and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same geographical region. This Plan will not cover amounts in excess of usual and reasonable charges. Usual and reasonable charges means a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same geographical region.

MEDICAL BENEFITS

Appendix A is provided to give you a quick reference of the amounts payable for each Medical Benefit. For detailed information about a specific Medical Benefit, you should refer to the benefit descriptions immediately following below:

1. Hospital Benefits – Inpatient Services. All inpatient hospital services require pre-certification and utilization review.

If you are confined in a hospital as a registered bed patient, you will be entitled coverage under this benefit for your hospital stay, including maternity care. After 23 observation hours, a hospital confinement will be considered an inpatient hospital stay. The Plan covers you for up to 365 days of each hospital admission.

Subject to the regulations of the Plan, the following hospital services provided on an inpatient basis will be covered based upon the payment schedule listed at Appendix A:

- Daily room and board;
- General nursing service;
- Intensive care unit service;
- Other medically necessary hospital services – including hospital diagnostic and therapeutic services for medical and surgical treatment of your illness, condition or injury;
- Newborn nursery care - room, board and other normal care for which a hospital makes a charge. Routine well newborn physician care covers the first pediatric visit to the newborn child after birth while hospital confined;
- Treatment related to Mastectomy. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:
    - All stages of reconstruction of the breast on which the mastectomy was performed;
    - surgery and reconstruction of the other breast to produce a symmetrical appearance;
    - prostheses; and

- treatment of physical complications of the mastectomy, including lymphedema.

- Maternity hospitalization – Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benefits are not provided for Dependent Children, except for Complications of Pregnancy.

Complications of Pregnancy mean: (1) conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy, or were caused by pregnancy, or (2) non-elective Caesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy which occurs during a period of gestation on which a viable birth is not possible.

- Physical therapy, physical medicine and rehabilitation - the Plan will cover up to 30 inpatient days per calendar year. Service must be rendered by a licensed physical therapist under order of a physician. Therapy must follow the physician's exact orders as to type, frequency and duration and must be needed to improve body function.

2. Hospital Benefits – Outpatient Services. All outpatient hospital services require utilization review (as described in Section XII Utilization Review Program) except Emergency accident care and Emergency medical care. Subject to the regulations of the Plan, the following outpatient hospital services will be covered:

- Outpatient surgical procedures – including care given by the hospital on the day of surgery, provided that it is consistent with and related to the surgery performed;

- Diagnostic x-rays and laboratory services;

- Emergency accident care;

- Emergency medical care;

- Pre-admission testing – if tests are necessary, a bed and operating room has been reserved prior to the testing, you are actually present in the hospital for such tests and the surgery

occurs within seven days of the tests, you must contact MagnaCare within one business day of admission for maximum reimbursement;

- Chemotherapy – if necessary for the diagnosis and treatment of malignant disease, treatment must be of the infusion or oral type. Such chemotherapy may be rendered in a hospital or in a freestanding facility;

- Physical therapy, physical medicine and rehabilitation – service must be rendered by a licensed physical therapist under order of a physician. Therapy must follow the physician's exact orders as to type, frequency and duration and must be needed to improve body function;

- Dialysis for kidney failure - the Plan will cover charges incurred for dialysis of the kidney if necessary to facilitate kidney function. Such dialysis may be rendered in the home and in a hospital or freestanding facility. Dialysis for kidney failure is subject to coverage by Medicare for End Stage Renal Disease when applicable.

3. Mental Health Treatment. All inpatient mental health treatment must be pre-certified. Any charges you incur for payment of mental health treatment will not accumulate toward the maximum out-of-pocket expense nor will charges for treatment of mental health be paid in full even if you satisfy the maximum out-of-pocket expense.

Mental health services are only covered if they are given in treatment of a mental or nervous disorder.

The Plan will cover inpatient and outpatient psychiatric care included with the 365 covered days of the inpatient hospital benefit. Physician visits are limited to one treatment per day.

4. Hospice Care. All hospice care must be pre-certified (as described in Section XII. Utilization Review Program). This benefit is limited to 210 days of coverage for both inpatient and outpatient care combined per covered person per lifetime.

The Plan covers hospice care that is provided by a hospice agency which has an operating certificate issued by the New York State Department of Health. If the care is provided outside New York, the hospice agency must have an operating certificate similar to those issued in New York.

Charges for hospice care services and supplies are covered only when the attending physician has diagnosed the covered person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a hospice care plan. A hospice

care plan is a plan of terminal patient care that is established and conducted by a hospice agency and supervised by a physician.

Covered services include:

- inpatient care in a hospice unit or other licensed facility;
- home care; and
- family counseling during the bereavement period.

5. Treatment of Alcoholism and/or Substance Use Disorder. All inpatient services must be pre-certified. Prior to incurring any costs, you must contact Project Outreach at the following telephone number and/or address:

Labor Systems Services
Telephone #: (570) 616 4111
Address: 324 Galilee Road
Damascus, Pennsylvania 18415

Any substance use disorder treatment that is not pre-certified by Project Outreach will not be covered.

There is no coverage if treatment is in connection with maintaining a driver's license due to driving while intoxicated (DWI).

Covered services include:

- Inpatient – the Plan will cover detoxification treatment as part of the 365 days of hospital coverage per calendar year.
- Outpatient – The Plan will cover outpatient detoxification treatment as part of the 365 days of hospital coverage per calendar year (20 visits may be used for family counseling).

6. Skilled Nursing Facility Care. All services must be pre-certified. It covers the room and board and nursing care furnished by a skilled nursing facility if:

- the patient is confined as a bed patient in the facility;
- the confinement starts within 14 days of a hospital confinement of at least three days;

- the attending physician certifies that the confinement is needed for further care of the condition that caused the hospital confinement; and

- the attending physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the skilled nursing facility.

A skilled nursing facility is a facility that meets all of the following standards:

- The facility is licensed to provide professional nursing services on an inpatient basis to a person convalescing from injury or sickness.

- The services must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse.

- The facility must provide services to help restore patients to self-care in essential daily living activities.

- The facility's services are provided for compensation and under the full-time supervision of a physician.

- The facility provides 24-hour-per-day nursing services by licensed nurses, under the direction of a full-time R.N.

- The facility maintains a complete medical record on each patient.

- The facility has an effective utilization review plan.

- The facility is not (other than incidentally) a place for rest, the aged, for the treatment of substance abuse addiction, mental disability, custodial care, educational care or care of mental disorders.

- The facility is approved and licensed by Medicare.

Charges incurred in a facility that satisfies the requirements of a skilled nursing facility but refers to itself as an extended care facility or convalescent nursing home (or any other similar name) will also be covered under the Skilled Nursing Facility Benefit in accordance with this Plan.

7. <u>Outpatient Private Duty Nursing.</u> All services must be pre-certified. It covers the services of a private duty registered nurse (R.N.) or a private duty licensed practical nurse (L.P.N.). The nursing must be ordered by a physician and require the skill of a R.N. or L.P.N.

8. <u>Home Health Care.</u> All services must be pre-certified. It covers charges for home health care services and supplies for care and treatment of an injury or sickness when hospital or skilled nursing facility confinement would otherwise be required. In other words, the home care visits are a substitution for hospital care or care in a skilled nursing facility.

The services and supplies covered include:

- part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.);
- part-time or intermittent home health aide services provided through a home health care agency (general housekeeping services excluded);
- physical, occupational and speech therapy;
- chemotherapy necessary for the diagnosis and treatment of a malignant disease, treatment must be of the infusion or oral type;
- dialysis for kidney failure necessary to facilitate kidney function;
- medical supplies; and
- laboratory services by or on behalf of the hospital.

A home health care agency is defined as follows:

- its main function is to provide home health care services and supplies;
- it is federally certified as a home health care agency; and
- it is licensed by the state in which it is located (if licensing is required).

A home health care plan must be submitted by the patient's attending physician to obtain pre-certification prior to any charges being incurred. After the initial review, the plan will be reviewed at least every 30 days to ensure the home health care plan is being followed to the physician's specifications. A home health care plan is a formal written plan made by the patient's attending physician containing:

- diagnosis;

- certification that the home health care is in place of hospital confinement; and

- specification of type and extent of home health care required for the treatment of the patient.

Benefit payments for nursing, home health aide and therapy services are limited to 200 visits per calendar year per covered person. A home health care visit will be considered a periodic visit by either a nurse or therapist or four hours of home health aide services.

9. Chiropractic Services. The Plan covers services rendered in connection with the detection or correction of structural imbalance by manual or mechanical means, distortion or subluxation of the vertebral column. This benefit is subject to a $500 per covered person calendar year maximum. Charges will not apply toward the 100% maximum out-of-pocket expense.

10. Orthotic Appliances. The Plan covers orthotic appliances if it is required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace.

11. Orthopedic Appliances. The Plan will cover for initial purchase, fitting, repair and replacement of orthopedic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an injury or sickness that occurred while covered under this Plan.

12. Occupational Therapy. The Plan will cover charges for occupational therapy only if it is rendered by a licensed occupational therapist and ordered by a physician because of an injury or sickness that occurred while you are covered under this Plan. Therapy must be needed to improve a body function. Covered expenses do not include recreational programs, maintenance therapy or any supplies used in occupational therapy.

13. Rental of Durable Medical Equipment. The Plan will cover charges for rental of durable medical equipment such as iron lung, wheelchair and hospital type bed. In order for equipment to be considered durable medical equipment it must be able to withstand repeated use, be primarily and customarily used to serve a medical purpose, not be useful to a person in the absence of an illness or injury and be appropriate for use in the home. Rentals in excess of the cost to purchase the equipment will not be covered; however, equipment may be purchased upon approval by the Fund Administrator.

14. Hearing Aids. The Plan will cover the expenses for preliminary tests and purchase of a hearing aid as prescribed by a physician. There is no reimbursement for expenses related to loss, theft or batteries.

The maximum reimbursement is $250 every three calendar years per eligible participant. However, if hearing aids are required for both ears, the maximum reimbursement is $500 every three calendar years per eligible participant.

15. Optical Benefit. Active employees and their eligible dependents age 19 and under are eligible for this benefit. Dependent children over age 19 are not covered (even if your dependent child is enrolled as a full-time student).

The Plan covers the expenses for eye examinations and prescription eyeglasses or contact lenses. The maximum amount of this benefit is $125 every two calendar years (beginning with even-numbered year) per covered person.

The following providers have an agreement with this Plan to offer you and your eligible dependents eye examinations and certain frames and lenses at discounted rates:

- Vision Screening:

You must identify yourself as a participant in this Plan at the time of service to receive the discounts.

16. Wig after Chemotherapy. During a course of chemotherapy, covers charges for one wig up to a lifetime maximum of $125 per covered person.

17. Routine Preventive Care. Routine Well Adult Care includes care by a physician that is not for an injury or sickness, such as, pap smears, mammograms, prostate screenings, gynecological exams and routine physicals.

Routine Well Child Care includes care by a physician that is not for an injury or sickness through age 19, such as routine physicals and immunizations.

In-network routine preventive care is not subject to a schedule and may be provided as your physician sees fit. If you use an out-of-network provider, the deductible will be waived but your benefits are subject to the following schedules:

i. Routine Well Child Care

Birth – age 5 ..... no limit

Age 6 – 19 ..... 1 exam every calendar year

ii. Routine Well Adult Care

Age 20 – 35, participants & dependents .....1 exam every calendar year

Age 36 – 55, participants only .....1 exam every calendar year

Age 56 +, participants only.....1 exam every calendar year

18. <u>Miscellaneous Medical Services and Supplies.</u> If the following services are not otherwise covered, they may be covered as follows:

- <u>Emergency transportation</u> - covers medically necessary ambulance service. A charge for this item will be covered only if the service is to the nearest hospital, but, in any event, no more than 50 miles from the place of pickup, unless a longer trip is medically necessary.

Transporting a covered person by train or air from the first area of care to and from a hospital in another area must be on a regularly scheduled carrier.

Benefits are subject to the following limits:

Type of Transportation	Maximum
Land Ambulance	Plan pays 70% of usual and reasonable charges after the deductible is met.
Air Ambulance	Plan pays 70% of usual and reasonable charges after the deductible is met.
Public Transportation	$1,000 per calendar year

- <u>Anesthetic and administration of anesthetic</u> – must be given by a physician who is not the surgeon, obstetrician or his assistant and rendered in a hospital, the outpatient department of a hospital or a state licensed birthing center;

- <u>Oxygen and administration of oxygen</u>;

- Blood and blood derivatives and administration of blood and blood derivatives that are not donated or replaced;

- Intravenous injections and solutions and administration of such injections and solutions;

- Cardiac rehabilitation – provided the services are rendered under the supervision of a physician in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery. Such treatment must be initiated within 12 weeks after other treatment for the medical condition necessitating the rehabilitation ends;

- Initial contact lenses or eyeglasses following cataract surgery;

- Prescription drugs – that are to be taken while confined in a hospital. This includes any institution that has a facility for the dispensing of pharmaceuticals on its premises;

- Prosthetic devices – provided charges are incurred for the initial purchase, fitting, repair and replacement of such devices which replace body parts if such loss occurred while covered under the Plan;

- Speech therapy – must be rendered by a licensed speech therapist, be ordered by a physician and follow surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person born while covered under this Plan; an injury or a sickness that is other than a learning or mental disorder;

- Sterilization procedures; and

- Surgical dressings – such as, splints, casts and other devices used in the reduction of fractures and dislocations.

LIMITATIONS AND EXCLUSIONS

LIMITATIONS

Benefits will be paid in accordance with the Plan and the following limitations:

1. Benefits Cover Specific Claims Only. Notwithstanding any other provision of this Plan, Benefits available under this Plan provide only for the payment of certain specific expenses. Benefits do NOT cover illnesses, conditions, diseases, injuries, etc. Thus, while the Plan will make payments for certain expenses you incur with respect to certain illnesses, conditions, diseases, injuries, etc., the Plan does not provide for the payment of all of the expenses you incur with

respect to a particular illness, condition, disease, injury, etc.

For example, if you sustain an injury which requires surgery, the surgeon's fee may be covered by your Medical Benefits. However, if the Plan were later amended to eliminate Medical Benefits and you subsequently required a second surgery with respect to the same injury, then the surgeon's fee for the second surgery would NOT be covered. Even though Medical Benefits were available when you sustained the injury, the expenses of the second surgery are not covered because Major Medical Benefits were NOT available when you incurred the specific claim for the second surgery.

2. Limitations on Surgical Procedures.

- Multiple Procedures - when multiple or bilateral surgical procedures, which add significant time or complexity to your care, are performed at the same operative session, whether through one or more incisions, the Plan will cover the major procedure and one-half of the payment otherwise payable for the lesser procedures. When an incidental procedure is performed through the same incision, the Plan will cover the major procedure only.

- Multiple Steps/Stages - when an operative procedure is performed in two or more steps, the total payment for the combination of steps which make up the entire procedure will be limited to the amount which the Plan would pay for such a procedure if it were not performed in steps.

EXCLUSIONS

In addition to any exclusions and limitations already listed on previous pages or in a booklet provided as an appendage to this booklet, a charge for any of the following is not covered:

1. Acupuncture, unless performed by a Medical Doctor;

2. Alcohol. Injuries and expenses incurred as a result of an accident, if, at the time of the accident, you were driving while intoxicated, or driving with ability impaired, or if you were a passenger in a vehicle being driven by someone who was driving while intoxicated, or driving with ability impaired;

3. Charges for services for **artificial insemination**;

4. Any **claim incurred prior to original coverage** under this Plan, or incurred during any period of termination of eligibility, or services which you are already receiving on the day your eligibility for benefits from this Plan begins;

5. Charges for **completion of claim forms** or other medical reports;

6. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered;

7. Services for palliative or **cosmetic foot care**;

8. **Cosmetic surgery,** except to the extent necessary to repair a disfigurement due to an injury or non-occupational accident sustained while covered for benefits and for reconstructive mammoplasty as described above;

9. Long-term convalescent or **custodial care**, domiciliary care or rest care;

10. **Diet supplements** or diet or weight loss programs;

11. **Educational or vocational training or testing** except Diabetes education;

12. **Employment related injuries** or sickness developing from or directly attributable to your employment or ailment or injury arising out of and in the course of your employment for which there is Workers' Compensation or Occupational Disease Law coverage;

13. **Excess charges.** Expenses which the Fund does not consider to be reasonable and customary;

14. **Exercise programs and equipment.** Health clubs, exercise equipment, swimming pools, bath massagers, whirlpools, treadmills, joggers, tanning equipment, environmental control equipment, non-medical equipment, and/or other equipment or items which are not used exclusively for medical treatment;

15. Any expense incurred for any drug, device, medical treatment or procedure which is considered **experimental** or investigational by the federal government or is not recognized as generally accepted by the American medical community. A drug, device, medical treatment or procedure is experimental or investigational:

    - if the drug or device cannot be lawfully marketed without approval of the U.S. FDA and approval for marketing has not been given at the time the drug or device is furnished; or

    - if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

    - if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental study

or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

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

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

16. Confinement, treatment, services or supplies provided by or in a United States Government or other **government hospital**, to the extent permitted by applicable law;

17. Care and treatment for **hair loss** including wigs, hair transplants or any drug that promises hair growth, except for wigs as covered under the Wig during Chemotherapy Benefit;

18. Care and treatment of an injury or sickness that is a direct result of a **hazardous hobby**. A hobby will be considered hazardous if it is an unusual activity which is characterized by a constant threat of danger or risk of bodily harm. Hazardous hobbies include, but are not limited to, the following:

- Skydiving;
- auto or motorcycle racing;
- hang gliding; or
- bungee jumping.

19. Charges for **holistic testing** and treatment;

20. Charges for **home reconstruction**, including those arising from special medical treatments in the patient's home;

21. Professional services billed by a physician or nurse who is a **hospital employee** or skilled nursing facility employee and who is paid by the hospital or facility for the service;

22. **Hypnosis**;

23. Charges related to an injury, condition or disease resulting from, or incurred while committing or being engaged in an **illegal act**. If you are convicted of committing or engaging in an illegal act, then such conviction will serve as proof that you committed or engaged in the illegal act. However, for purposes of this exclusion, you will also be deemed to have committed or engaged in an illegal act to the extent that the Trustees determine that you committed or engaged in such illegal act, based upon the facts and circumstances involved, even if a criminal prosecution does or does not result in you being found guilty;

24. Services, supplies, care or treatment to a covered person for injury or illness resulting from his or her voluntary taking of or being under the influence of any **illegal drugs or medications** not prescribed by a physician. Expenses will be covered if a covered person is injured do to another person's intake of or being under the influence of an illegal drug or medication not prescribed by a physician whether or not the person inflicting such injury is covered under the Plan;

25. Charges for **invitro-fertilization**;

26. **Maternity** benefits for dependent children; except for complications of pregnancy.

27. Services for which payment has been made under Medicare, or would have been **Medicare payable expenses** if you had applied for Medicare and claimed Medicare benefits, to the extent allowed by law; (all treatment not covered by Medicare)

28. Services or treatment for which there is **no charge** or for which you would not incur a charge if you were not covered under this Plan;

29. Charges billed by a hospital for **non-emergency admissions** in excess of the usual and reasonable charges for care and treatment because such admission was on a Friday or Saturday. This does not apply if surgery is performed within 24 hours of admission;

30. Charges incurred for which the Fund has **no obligation to pay**;

31. Services which are **not medically necessary**, as determined by the Trustees;

32. Expenses for services **not prescribed by a licensed physician** (unless explicitly authorized by other provisions of this Plan);

33. Services **not related to the treatment of a specific illness** or injury;

34. Charges for services **not specified as covered**;

35. Services for treatment of **obesity, weight loss or dietary control** whether or not it is, in any case, part of the treatment plan for another illness, except for surgical treatment of morbid obesity;

36. **Personal comfort** or entertainment items such as television, telephone, contour furniture, air conditioners, air filters, trips or relocation to different climates, etc.;

37. **Physicals** required as a condition of employment;

38. Charges incurred for a **pre-marital exam**;

39. Charges for a **private hospital room** unless such room is determined to be medically necessary and was prescribed by a licensed physician;

40. Services rendered by a **relative** (individual in your family or in your spouse's family);

41. **Replacement of braces** of the leg, arm, back, neck, or artificial arms or legs unless there is sufficient change in the covered person's physical condition making the original device no longer functional;

42. Care and treatment for the **reversal of surgical sterilization**;

43. Charges for **routine examination** or check-ups, except to the extent they are otherwise explicitly covered;

44. **Sales taxes**;

45. Any loss due to an intentionally **self-inflicted injury**, unless sustained due to an underlying mental health medical diagnosis such as depression or as a result of domestic violence;

46. Services for treatment of **sexual dysfunction** not related to organic disease;

47. Care and treatment of **sleep disorders** unless deemed medically necessary;

48. Charges for **smoke cessation** programs unless due to a severe active lung illness such as emphysema or asthma or permissible under the Affordable Care Act (nicotine patch);

49. Charges for **telephone conversations**;

50. All diagnostic and treatment services related to the treatment of jaw joint problems including **temporomandibular joint syndrome** (TMJ);

51. Services for which you have other health coverage, or for which some other **third party is responsible**, in accordance with other provisions of this Plan;

52. Transportation, except local ambulance service;

53. Services for treatment leading to or in connection with **transsexual surgery**;
54. Services related to an injury or ailment incurred as a result of terrorism or **war**, declared or undeclared, including armed aggression.

55. Services performed **outside the United States** except on an emergency basis.

UTILIZATION REVIEW PROGRAM

The Utilization Review Program is designed to help insure that you (as a covered person) and all covered persons receive necessary and appropriate health care while avoiding unnecessary expense.

Its apparent that a Utilization Review Program will benefit the Plan, what may not be so obvious is how a Utilization Review Program benefits you. Since you are responsible for a portion of the cost incurred for covered services, eliminating unnecessary charges and maintaining a reasonable fee structure will have a direct affect on the cost you will incur.

You cannot apply any additional costs that you incur (due to your failure to properly follow the Utilization Review Program) toward the Plan's maximum out-of-pocket expense.

The purpose of this program is to determine what is payable by the Plan. The program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending physician or other health care provider.

The Utilization Review Program consists of:

- pre-certification of the medical necessity for non-emergency hospitalizations and all nursing care, home health care and hospice care;

- retrospective review of the medical necessity of the listed services provided on a emergency basis;
- concurrent review and planning for discharge based on the admitting diagnosis of the listed services requested by the attending physician;
- a second and/or third opinion program;
- pre-admission testing service; and
- case management.

At first glance, this may appear to be a lot of work to save a little money. Actually there is little involved for you to do. In the long run, following the Utilization Review Program will save you time as well as money.

The following sections explain each step of the Utilization Review Program.

You or a family member must call the telephone number listed below to receive certification of certain services. This call must be made during business hours at least seven days in advance of services being rendered or within one business day after an emergency. Business hours are 8:30 a.m. to 5:00 p.m., seven days a week.

MagnaCare: (800) 362-4624

PRECERTIFICATION

The following services must be precertified or payment from the Plan may be reduced or denied:

- Home health care,
- Diagnostic testing at freestanding facilities and outpatient hospitals;
- Outpatient surgery (facility fee and physician/surgeon fees);
- Hospital stay;
- Physician/surgeon fees;

- Mental health, behavioral health, or substance use disorder services;
- Rehabilitation services for inpatient admissions;
- Childbirth/delivery professional and facility services if stay is over 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery;
- In-patient or out-patient nursing care, and
- Hospice care,
- Transportation.

If a particular course of treatment or medical service is not certified in advance of such treatment or medical service, the Plan will not consider that course of treatment as appropriate for the maximum reimbursement.

1. Alcohol and/or Substance Abuse Treatment Pre-Certification Procedures. All alcohol and/or substance abuse treatment services must be pre-certified. Prior to incurring any costs, you must contact at the following telephone number and/or address:

Labor Systems Services
Telephone #: (570) 616 4111
Address: 324 Galilee Road
Damascus, Pennsylvania 18415

2. Pre-Certification Procedures For All Other Services Requiring Pre-Certification. Before you enter a medical care facility on a non-emergency basis, the Utilization Review Program administrator will, in conjunction with the attending physician, certify the care as appropriate for Plan reimbursement. If a covered service is deemed to be appropriate for Plan reimbursement, your portion of the cost will be significantly lower than had you not pre-certified the service.

The first step to having a service reviewed for reimbursement is up to you. You should contact the Utilization Review Program administrator at least **seven days before** services are scheduled to be rendered at:

MagnaCare: (800) 362-4624

Before you place the call, be sure to have the following information:

- name of the patient and relationship to the covered person;

- name, social security number and address of the covered person;
- name of the covered person's employer;
- name and telephone number of the attending physician;
- name of the medical care facility, proposed date of admission and proposed length of stay;
- diagnosis and/or type of surgery; and
- proposed rendering of listed medical services.

CONCURRENT REVIEW & DISCHARGE PLANNING

Concurrent review of a course of treatment and discharge planning from a medical care facility are parts of the Utilization Review Program. The Utilization Review Program administrator will monitor the covered person's medical care facility stay or use of other medical services and coordinate with the attending physician, the medical care facility and the covered person either the schedule release or an extension of the stay or extension or cessation of the use of other medical services.

If the attending physician feels that it is medically necessary for a covered person to receive additional services or to stay in the medical care facility for a greater length of time than has been pre-certified, the attending physician must request the additional services or days.

SECOND AND/OR THIRD OPINION

Certain surgical procedures are often performed inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition at all. This program has been developed to help prevent unnecessary or potentially harmful procedures.

The Plan provides coverage for second (and third, if necessary,) opinion consultation to determine the medical necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

You may choose any board certified specialist who is not an associate of the attending physician and who is affiliated in the appropriate specialty.

The following is a list of surgeries that are often performed when other treatments are available:

- appendectomy;
- cataract surgery;
- cholecystectomy (removal of the gall bladder);
- surgery for repair of a deviated septum (nose surgery);
- hemorrhoidectomy;
- hernia surgery;
- hysterectomy;
- mastectomy;
- prostate surgery;
- salpingo-oophorectomy (removal of tubes/ovaries);
- spinal surgery;
- surgery to the knee, shoulder, elbow or toe;
- tonsillectomy and adenoidectomy;
- tympanotomy (surgery of the inner ear); and
- varicose vein ligation.

The second and/or third opinion program is not limited to the surgeries listed above; you may seek a second opinion for any surgical procedure.

PRE-ADMISSION TESTING SERVICE

The Plan will pay 100% for diagnostic lab tests and x-ray exams if:

- they are performed on an outpatient basis within seven days before a hospital confinement;

- they are related to the condition which causes the need for the hospital confinement; and

- they are performed in place of tests that would have otherwise been performed while hospital confined.

Covered charges for this testing will be payable at 100% even if tests show the condition requires medical treatment prior to hospital confinement or the hospital confinement is not required. The deductible will also be waived for these tests.

LARGE CASE MANAGEMENT

A patient will require long-term care when a catastrophic condition such as a spinal cord injury, a degenerative sickness or a neurological paralytic disease occurs. After the patient's condition is stabilized in the hospital, he or she may be able to be moved into another type of care setting, maybe even to his or her home. Sometimes specialized care is required, large case management was initiated for these situations.

Large case management occurs in the following situations:

- The catastrophic injury or sickness must have occurred while the patient was a covered person and the injury or sickness must have been a covered service under the Plan.

- The patient has been hospitalized and the attending physician feels the condition is stabilized.

- The patient must continue to require an acute level of care but that care need not be administered in a hospital.

The case manager will coordinate and implement the large case management by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending physician, patient and the patient's family must all agree to the alternate treatment plan. Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for expenses as stated in the treatment plan.
NOTE: Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even patients with the same diagnosis.

PRESCRIPTION BENEFIT

Eligible active and retired participants and their eligible dependents will be covered for Prescription Drug Benefits upon proper application in accordance with payment schedule set forth by Appendix B. Your Prescription Drug Benefits are administered through Optum RX. The contact information is below:

Optum RX
1 885 295 9140
P.O. Box 29044
Hot Springs, Arizona 71903

A. COVERED EXPENSES

The following charges will be covered under this Section:

- Drugs prescribed by a physician which require a prescription either by federal or state law, with the exception of a drug that is specifically excluded by the Plan;

- Compound prescriptions containing at least one prescription ingredient in a therapeutic quantity; and

- Insulin (when prescribed by a physician).

B. EXCLUSIONS

Your Plan **excludes** the following:

- Drugs which are lawfully obtainable without a prescription, except injectable insulin;

- Therapeutic devices or appliances, including hypodermic needles, support garments and other non-medical substances, regardless of their intended use;

- Any charge for the administration of prescription drugs, except for those charges required by law to be covered;

- Drugs labeled: “Caution-limited by federal law to investigational use” or any experimental drugs, even if a charge is made;

- Prescription refills over the number of times specified by the physician;

- Prescriptions refilled after one year from the order of a physician;

- Drugs and injectable insulin dispensed during confinement in a hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises a facility for dispensing pharmaceuticals; or

- Prescription drugs which may be properly received without charge under local, state or federal programs.

C. HAVING YOUR PRESCRIPTION FILLED AT A PHARMACY

Participating pharmacies have contracted with the Plan to charge covered persons reduced fees for covered prescription drugs. Optum is the administrator of the pharmacy drug plan.

You may use your identification card at any participating pharmacy. If you have any questions regarding whether your pharmacy participates, please contact Customer Service Department toll free at. Optum participating pharmacies have the necessary forms.

Once the pharmacist has dispensed your medication and completed the claim form, you will be asked to sign the form and pay the co-payment for each new or refill prescription received. The pharmacist will mail the form to Optum for processing. There is no coverage for prescriptions purchased from a non-participating pharmacy or from a participating pharmacy if you fail to show your identification card at the time you have the prescription filled.

FOR ACTIVE PARTICIPANTS AND ELIGIBLE DEPENDENTS AND PRE-MEDICARE ELIGIBLE RETIREES

Retail Pharmacy Coinsurance. Prescription will be the lesser of 20% of the cost of the prescription or $15 (Generic) or Lesser of 20% or $25 (Retail);

Mail Copay. **$30/$60/$100**

Specialty Coinsurance. 20% of cost of prescription.

Supply and Refill. Any one prescription is limited to a 21-day supply with two refills for active participants and their eligible dependents and a 21-day supply and one refill for retirees and their eligible dependents.

Any narcotic, pain management prescription or prescription unable to be obtained via the mail away program will be limited to a 30-day supply with one refill for active and retired participants and their eligible dependents.

MAIL ORDER PROGRAM

The mail order drug program is provided through Optum and is mandatory for all long term maintenance medications such as: heart medication, blood pressure medication, diabetic medication, etc. If you require a maintenance medication, you must contact the Fund Office for the proper forms Optum address as follows:

Optum RX
1 885 295 9140
P.O. Box 29044
Hot Springs, Arizona 71903

1. Name Brand Excess Cost. If a physician prescribes a name brand and a generic equivalent is available, you will be responsible for the applicable co-payment as well as the difference in price between the name brand drug and the generic drug.

2. Supply and Refill. You can obtain a 90-day supply of your prescription through the mail order program and refills are covered as prescribed by your physician.

3. Advantages of Using the Mail Order Program. The benefits of the mail order program include greater convenience and less cost to you because:

- you do not have to continually visit your physician for each refill;
- your prescription will be mailed directly to your home;
- you do not have to visit your physician as frequently therefore reducing office visit co-payments and coinsurance;
- you are allowed a larger supply per prescription consequently incurring less frequent prescription co-payments; and
- you are charged a lower co-payment.

E. CO-PAYMENTS AND REBATES

The Plan receives rebates from Optum for certain drugs purchased from pharmaceutical manufacturers. Rebates the Plan anticipates receiving are used to reduce co-payments that apply under the Plan.

MEDICAL REIMBURSEMENT ARRANGEMENT

The Trustees have established a "Medical Reimbursement Arrangement" (the "**MRA**") that is designed to reimburse you for your out-of-pocket medical and dental expenses incurred during the calendar year.

What is the purpose of the MRA?

The purpose of the **MRA** is to provide a source of funds to reimburse eligible participants and beneficiaries covered under the **MRA** for some or all of the uninsured medical and dental expenses they incur in the course of each year while they are in covered employment and the **MRA** remains in effect.

Who can participate in the MRA?

Each eligible participant or dependent of who maintains eligibility under the Plan according to Section I.

How much of my uninsured medical and dental expenses may be reimbursed each year?

You may be reimbursed up to the maximum in your account for any calendar year. Any of this annual amount that is left over at the end of the **MRA** Plan Year will be carried over to future Plan Years for the sole purpose of reimbursing you for your eligible medical and dental expenses.

How do I receive my benefits under the MRA?

When you incur an eligible expense, you must submit a claim to the Fund Administrator on a *Claim Voucher* that will be supplied to you. If the Fund Administrator determines that your claim is valid, you will be reimbursed for your eligible expenses as soon as is administratively feasible after it has been submitted. Remember, though, you can't be reimbursed for any total expenses above the annual amount of your account balance. If your claim arises while you have COBRA continuation coverage, all required premiums for the coverage (subject to a 30-day grace period for late payment of premiums) also must have been received by the Plan.

How do I file a claim for benefits?

How you file a claim for benefits depends on the type of claim it is. There are several categories of benefits:

- *Concurrent Care Claim*—A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.
- *Pre-Service Care Claim*—A pre-service claim is a claim for a benefit under the **MRA** with respect to which the terms of the **MRA** require approval (usually referred to as precertification) of the benefit in advance of obtaining medical care.
- *Post-Service Care Claim*—A post-service claim is a claim for a benefit under the **MRA** that is not a pre-service claim.
- *Urgent Care Claim*—An urgent care claim is any claim for medical care or treatment with respect to which, in the opinion of the treating physician, lack of immediate processing of the claim could seriously jeopardize the life or health of you or your insured dependent or subject you or your dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

You may file any claim for benefits, including ones for concurrent care, pre-service care, or post-service care, yourself, by your authorized representative, or by your health care service provider. Any of these types of claims must be filed using a written form supplied by the Fund Administrator and may be submitted by U.S. Mail, by hand delivery, by facsimile (FAX), or as an as an attachment to electronic mail (e-mail). Telephone submissions using the toll-free telephone number set out above will be processed conditionally, subject to receipt of the required format by any of the delivery methods described in the preceding sentence.

If your claim involves urgent care, you may initiate a claim for urgent care benefits yourself if you are able, or your treating physician may file the claim for you. The claim may be made by telephone (using the toll-free telephone number set out above, or by U.S. Mail, by hand delivery, by facsimile (FAX), or as an attachment to electronic mail (e-mail). If your claim is filed by telephone, you will be responsible for completing any follow-up paperwork the **MRA** may require in support of your claim.

You may file any claim yourself, or you may designate another person as your “authorized representative” by notifying the Plan Administrator in writing of that person's designation. In that case, all subsequent notices will be provided you through your authorized representative, and decisions concerning that claim will be forwarded to your authorized representative.

The Fund Administrator provides forms for filing those claims and authorized representative designations under the **MRA** that must be filed in writing. You may submit a claim for benefits up to 90 days after the close of the plan year. For example, assume the plan year ends on December 31st. You or your dependent incurs a medical expense on December 31st. You have until 90 days after December 31st (or March 31st of the next year) to submit this medical claim for payment.

If your employment ends and your coverage ceases, you have 90 days after the date your coverage ceases to submit claims.

What is an "eligible expense?"

An "eligible expense" means any item for which you could have claimed a medical expense deduction on an itemized federal income tax return for which you have not otherwise been reimbursed from this Plan, or some other source. However, the Plan will not reimburse you for the cost of prescription drugs obtained outside of the United States because of the uncertainty of whether obtaining medications from a foreign source in any particular instance violates federal laws or regulations.

What Expenses Can be Claimed

- Only expenses for services INCURRED during the plan year can be claimed for reimbursement.
- Expenses are incurred when you are provided the Health Care related service that gives rise to the expense and not when you are formally billed or charged for or pay for the expense.
- An expense must be qualifying as defined under Section 213(d) of the Internal Revenue Code.

You are also encouraged to consult your personal tax advisor or IRS Publication 502 "Medical and Dental Expenses" for further guidance as to what is or is not an eligible expense if you have any doubts.

How to Complete the Form

- When completing the Health Care expense section, list each claim expense separately on the form. **You cannot combine expenses that are listed on separate documents that may substantiate your expense. For example, if you have 30 prescription receipts, you must enter them as 30 separate claims on the form. However, if more than one eligible expense incurred on the same day is listed on one document, you may enter those expenses as one claim.**

- **You must make an entry for each expense incurred on a given date and provide supporting documentation.** Once you have listed all claims, total the amounts and list the total in the "Total Reimbursement Requested" box.
- Read the Health Care Expense Certification carefully; then sign and date the form.

Supporting Documentation

- Include photocopies of your supporting documentation to this claim form. Please DO NOT send original receipts.
- Supporting documentation must contain the following information:
  - Provider Name
  - Date the service was incurred
  - Recipient of the service
  - Description of the service provided
  - Expense amount
- Receipts for Over the Counter expenses that do not clearly identify the product being purchased must be accompanied by a copy of the box or container for each product in which you are requesting reimbursement.
- If any of these expenses were covered by insurance, attach a copy of the "Explanation of Benefits" from you insurance company as documentation.
- Cancelled checks and credit card statements/receipts are not considered valid supporting documentation. **The IRS has determined that canceled checks, check carbons, balance forward, previous balance statements, charge card receipts or statements are not acceptable documentation of expenses. An Explanation of Benefits must be provided when available.**

Does the plan also provide benefits for my family?

The **MRA** provides reimbursement for expenses incurred for you, your spouse, and any other person you could claim as an eligible dependent defined by the Plan. **Does my coverage under this MRA end when my employment terminates?**

Yes. Your normal participation will cease once your eligibility under the Plan ceases. However, you and your family will have the opportunity to continue to be covered under the **MRA** under the terms of the Continuation Coverage provisions.

Will my coverage end if I go on a family or medical leave under the FMLA?

Subject to certain conditions, the Family and Medical Leave Act ("FMLA") entitles you to take unpaid leaves of absence totaling 12 weeks per year for specific personal or family health and child care needs. Your coverage under the **MRA** will continue while you are on an FMLA leave at no cost to you. However, you will lose coverage (subject to your right to elect Continuation Coverage) when you fail to return to work at the end of the leave or give earlier notice that you will not be returning to active employment.

Does my coverage continue while I am absent on duty in the uniformed services?

The **MRA** will continue to reimburse your family medical expenses (except for any illness or injury suffered by you in connection with duty in the uniformed services) for the first 12 weeks of your absence. Thereafter, you may elect Continuation Coverage under the **MRA** at your own expense for up to 18 months.

The "uniformed services" are the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency. Important Notice -

The Trustees reserve the right to amend, modify or discontinue all or part of the Fund or the benefits provided to Local 138 participants and their families whenever, in the Trustees' judgment, conditions so warrant.

Claims Review

The claims review procedure is described on page 65 of this booklet.

No Guarantee of Tax Consequences

No commitment or guarantee is made that any benefit or other payment from the MRA accounts will not be subject to Federal or state taxes. Participants are responsible for determining whether benefits and other payments received from the MRA accounts are subject to tax.

You will be eligible to become a participant if an employer contribution is made on your behalf and you are available for covered employment. If the Fund Office receives a contribution made on your behalf, you will receive an enrollment application. You must complete and return the enrollment application to become a participant.

You will become a participant on the first day of the month following the receipt of your properly completed enrollment application. Benefits will not be provided for the period before you become a participant.

When does my participation end?

You will no longer be a participant 30 days after the balance of your account drops to zero. You will also cease to be a participant if during a continuous 24-month period, no employer contributions are received on your behalf and no benefit distributions are made from your HRA account.

What happens to my account balance when I am no longer a participant?

The accounts of participants who lose their participant status will be reduced to zero. The account balances of participant who lose their participant status will not be reinstated under any circumstances.

I used to be a participant. Can I become a participant again?

A former participant must meet the eligibility and enrollment requirement to become a participant again. The account balances of a former participant will not be reinstated.

When do my dependents become eligible for benefits?

Your dependents become eligible for health and dental reimbursement benefits when your participation begins and you complete and return the necessary enrollment application.

Do I own my individual account balance?

No. Because my account balance is used only for bookkeeping purposes to determine my eligibility for benefits, amounts are not actually deposited in your account in the same manner as if it was a bank account and you do not have an ownership interest in your account balance. When benefits are paid to you, your MRA account is correspondingly reduced; however, all benefits are actually paid from the Fund's general assets.

YOUR RIGHTS TO CONTINUE YOUR COVERAGE DUE TO CERTAIN "QUALIFYING EVENTS" AS DESCRIBED BELOW ("COBRA")

In some circumstances, it may be possible for you and/or your dependents to continue coverage under the Welfare Plan even when your coverage would have otherwise terminated. You may also be eligible for coverage through the New York State Exchanges.

A. COBRA CONTINUATION COVERAGE

If your Welfare Plan coverage is terminated, you may be entitled to continue your coverage on a self-pay basis in accordance with The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA provides that you and your eligible dependents are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop.

For individuals covered by the Plan as employees, COBRA continuation coverage may be elected upon loss of coverage under the Plan due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer meets the eligibility requirements of the Plan due to a reduction in hours of covered employment. Being unavailable for covered employment for reasons other than sickness or disability shall be deemed a termination of employment.

Your spouse may elect COBRA continuation coverage if he or she loses coverage because of the occurrence of any of the following events:

- your death;
- your spouse's loss of coverage under the Plan due to voluntary or involuntary termination of your employment (except for gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in your hours of covered employment;
- divorce or legal separation; or
- you become entitled to Medicare (even if such entitlement occurs while you and/or your spouse is already receiving COBRA continuation coverage).

Your dependent child may elect COBRA continuation coverage upon the occurrence of any of the following events:

- your death;

- termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in your hours of covered employment;

- divorce or legal separation of you and your spouse;

- you become entitled to Medicare (even if such entitlement occurs while you and/or your dependent child is already receiving COBRA continuation coverage); or

- the child ceases to qualify as an "eligible dependent" as described in this Plan.

If, while you are receiving COBRA continuation coverage, you have a newborn child or adopt a child (or have a child placed with you for adoption), the child may be added to your coverage. You must, however, notify the Fund Office immediately of such a change. Such a child's coverage period will be determined according to the date of the qualifying event that gave rise to your COBRA coverage.

Under COBRA, you (or your spouse or dependent child, if applicable) must notify the Fund Office within 60 days after:

- you and your spouse are divorced or legally separated; or

- one of your children loses his or her dependent status under the Plan.

You (or your spouse or dependent child, if applicable,) will then be notified of your right to elect continuation coverage and the cost to do so. The deadline for electing continuation coverage is 60 days after the date the Welfare Plan ceases to cover you or from the date you are notified, whichever is later.

If you (or your spouse or dependent child, if applicable,) do not elect continuation coverage, your coverage will stop. If you (or your spouse or dependent child, if applicable,) choose continuation coverage, the Welfare Plan will provide coverage identical to that available to similarly situated active employees, including the opportunity to choose among options available during open enrollment. However, you (or your spouse or dependent child, if applicable,) must pay the full cost of this coverage.

If a covered employee or spouse of a covered employee elects COBRA without specifying whether the election is for self-only coverage, the election will be considered to be on behalf of all other qualified beneficiaries with respect to that qualifying event.

Duration of Continuation Coverage.

(a) Once elected, and subject to the premium requirements set out above, Continuation Coverage shall be retroactive to the date that coverage otherwise would have ended, and is the starting point for determining the remaining period for which the Plan must still continue to provide the individual or other Qualified Beneficiaries in his family with the opportunity for maintaining Continuation Coverage, i.e., 18 month, 29 months, or 36 months, as the case may be.

(b) Such coverage shall extend for a period of 18 months after the date that regular coverage ends due to the Employee's termination of employment or reduction of hours of employment to a level that disqualifies him from participation in the Plan, or for a period of 29 months if the Social Security Administration (SSA) determines within the 18-month period that any Qualified Beneficiary was disabled during the first 60 days of Continuation Coverage. If the Covered Employee was entitled to Medicare benefits at the time of the Qualifying Event of his termination of employment or reduction of hours, each covered dependent shall be eligible to continue coverage for up to 36 months from the date the Covered Employee first became so entitled. For purposes of determining continuation coverage rights "entitlement" means actual enrollment for Medicare benefits.

(c) In order to secure the extended coverage after a determination of disability, the disabled Qualified Beneficiary must notify the plan administrator of SSA's finding within 45 days of its issue. If, during the 18-month period, a subsequent Qualifying Event occurs, the Covered Employee and each other Qualified Beneficiary having Continuation Coverage shall be entitled to elect to continue coverage under the Plan for up to 36 months following the date coverage was originally lost due to termination of employment or reduction of hours.

(d) In addition, 36 months of Continuation Coverage shall be available to: (i) the Covered Employee's spouse who loses coverage under this plan by ceasing to be a "Dependent" by virtue of a divorce or legal separation; (ii) a dependent child of the Covered Employee who loses coverage by ceasing to be a dependent as defined by the Plan; (iii) any covered dependent who loses coverage where the Qualifying Event is the Covered Employee's death; or (iv) any covered dependent, where the Covered Employee's entitlement to Medicare benefits results in loss of coverage under this Plan. In no event, however, shall Continuation Coverage extend more than 36 months beyond the date of the original Qualifying Event.

(e) In the case of a retired covered Employee who is a Qualified Beneficiary on the day before the Company files a bankruptcy proceeding under title 11 of the Bankruptcy Code that results in a substantial elimination of coverage for any Qualified Beneficiary within one year before or after the filing, coverage may continue until the date of death of the retired Employee, and, in the case of his or her surviving spouse and covered Dependents, 36 months after the date of the retiree's death.

Your (or your spouse's or dependent child's, if applicable,) right to continuation coverage under COBRA ends if:

- The Plan ceases to provide group health coverage;
- You (or your spouse or dependent child, if applicable,) fail to pay the premium within 30 days after its monthly due date;
- You (or your spouse or dependent child, if applicable,) becomes covered, after the date of your COBRA election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary (other than an exclusion or limitation that may be disregarded under the law);
- You (or your spouse or dependent child, if applicable,) becomes entitled to Medicare after the date of the COBRA election;
- You (or your spouse or dependent child, if applicable,) have extended continuation coverage due to a disability and then you are determined by the Social Security Administration to be no longer disabled;
- The maximum required COBRA continuation period expires; or
- For such cause, such as fraudulent claims submission, that would result in termination of coverage for similarly situated active employees.

B. CONTINUATION OF COVERAGE FOR QUALIFIED MILITARY SERVICE

If you leave employment for full-time Qualified Military Service, as defined by federal law, you and your eligible dependents are permitted to elect to continue health coverage under the Plan, subject to certain limitations under federal law. This coverage, subject to the rules of the Plan, must last for up to 18 months beginning on the date of your absence from employment. However, the coverage will terminate before the end of the 18 month period if you enter Qualified Military Service and are discharged earlier and fail to make timely application for re-employment upon discharge.

If you elect such continuation, you will not be required to pay any premium for the first 30 days of coverage. Thereafter, and until the cessation of such coverage, you will be required to make a monthly premium payment to the Plan.

C. CONTINUATION OF COVERAGE UNDER THE FAMILY MEDICAL LEAVE ACT

Under federal law, you may be eligible for up to twelve weeks of unpaid leave from your employment for any of the following reasons:

- you need to care for your newly-born or newly-adopted child,
- you need to care for your spouse, child or parent who has a serious health problem, or
- you have a serious health problem which prevents you from performing your job.

If you qualify for such a leave, you (and your eligible dependents, if any,) will continue to participate in the Plan just as if your work in covered employment had not stopped, unless your employer fails to make the required contributions for you. If you do not return to work at the end of your leave, you may be responsible for repaying the employer contributions made during the leave. You should contact your employer for further information about your eligibility for such a leave.

MAINTAINING THE PRIVACY OF YOUR HEALTH INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), provides your health information with important protections. HIPAA requires that the Fund maintain the privacy of your protected health information (PHI). PHI is information the Fund has or receives that can identify an individual and that relates to any medical, prescription, dental, vision and/or Members Assistance Program benefits that you receive from the Fund, regardless of the form in which it is provided.

The Fund also is required by HIPAA to provide you with this description of the privacy policies and practices adopted by the Fund to safeguard PHI. The Fund must follow these policies and practices but, as permitted by law, the Fund reserves the right to amend or modify them. Revisions to these policies and practices may be required by changes in federal and state laws and regulations. Regardless of the reason for the change, we will provide you with notice of any material change to the Fund's privacy policies and practices within sixty (60) days of the change.

Does HIPAA permit the Fund to disclose my PHI to my employer? Under HIPAA, the Fund generally cannot disclose your PHI to your employer without your written authorization. It is important to note, however, that HIPAA does permit the Fund to disclose your PHI without your authorization to workers' compensation carriers, or others involved in the workers'

compensation system, to the extent the disclosure is required by law as described below in further detail.

The privacy policy of the Fund is broken down into the following categories:

I. The Fund's uses and disclosures of PHI;

II. Your privacy rights with respect to your PHI;

III. The Fund's duties with respect to your PHI;

IV. Your right to file a complaint with the Fund and to the Secretary of the U.S. Department of Health and Human Services; and

V. The person or office to contact for further information about the Fund's privacy practices.

I. The Fund's Uses and Disclosures of PHI

Permitted PHI Uses and Disclosures that do not require your permission to use or release.

The use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Fund's compliance with the privacy regulations. The Fund is also allowed to use and disclose your PHI without your permission under the following circumstances:

(1) For treatment, payment and health care operations.

How may the Fund use my PHI with respect to payment for my treatment, payment and health care operations? The Fund may use your PHI for the broad range of actions needed to make sure that the Fund can make payments for the services that you and your family are eligible to receive. The Fund may use your PHI for making payments to providers for services or treatment that you receive, for making arrangements for payments through one of the networks of providers through which the Fund provides benefits to you, and for coordinating payments to providers through other health Funds under the Fund's coordination of benefit rules.

a. *Treatment* is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Fund may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

b. *Payment* includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical

necessity and appropriateness of care, utilization review and preauthorization). For example, the Fund may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund.

c. *Health care operations* include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business Funding and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes. For example, the Fund may use information to project future benefit costs or audit the accuracy of its claims processing functions

How may the Fund use my PHI with respect to health care operations? HIPAA allows the Fund to disclose an individual's PHI, without an authorization, to help the Fund assess the quality of the Fund's benefits as well as to monitor the Fund's administration and operations. These disclosures include, but are not limited to, disclosures to ensure that participants or their beneficiaries are eligible for benefits prior to making payments; disclosures to recover overpayments; disclosures to assess health Fund performance; disclosures to review the Fund's benefits and determine whether a reduction in costs is possible; disclosures to pursue case management and coordination of care; disclosures for actuarial studies relating to the cost of benefits and management studies relating to the operation and administration of the Fund; disclosures to resolve internal grievances; and disclosures as part of medical review, legal, and auditing functions. For example, the Fund may use PHI to determine the most cost-effective manner of providing vision benefits to its participants and beneficiaries. The Fund and its business associates (and any health insurers providing benefits to Fund participants) may also disclose the following to the Fund's Board of Trustees: (1) PHI for purposes related to Fund administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Fund; and (3) enrollment information (whether an individual is eligible for benefits under the Fund). The Trustees have amended the Fund to protect your PHI as required by federal law.

(2) Enrollment information provided to the Trustees.

(3) Summary health information provided to the Trustees for the purposes of treatment, payment, and health care operations.

(4) When required by law.

(5) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have

been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

(6) When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform a minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

(7) To a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(8) The Fund may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.

(9) When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Fund is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Fund's best judgment.

(10) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(11) When consistent with applicable law and standards of ethical conduct if the Fund, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

PHI Use and Disclosures that require you the opportunity to object prior to its use or release.

There are instances where uses and disclosures of your PHI require that you be given an opportunity to agree or disagree prior to the use or release. Unless you object, the Fund may provide relevant portions of your PHI to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Fund will disclose PHI (as the Fund determines) in your best interest. After the emergency, the Fund will give you the opportunity to object to future disclosures to family and friends.

Because I am always working, my spouse often calls to find out the status of my health claims and to get other information about me or my benefits. Can the Fund release information relating to payment of my claims to my spouse? The Fund will **not** provide claims payment or other PHI about you to your spouse **unless** you file a written authorization form with the Fund office, as described later in this Notice.

May I call the Fund to get information about my children's health claims? The Fund will provide a minor child's parent, guardian (or person standing *in loco parentis* with respect to the child) with payment information about the child's claims.

The Fund will carefully consider your written request for information other than claims payment information, and will respond as permitted by its privacy policies and applicable state law.

If your child is **not** a minor, the Fund cannot provide you with the child's PHI, even if the child is still covered under the Fund as your dependent, unless the child files an authorization form with the Fund office, as described later in this Notice.

PHI Use and Disclosures that you must give us authorization to use or release.

Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Fund will not use or disclose your psychiatric notes; the Fund will not use or disclose your PHI for marketing; and the Fund will not sell your PHI, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Fund receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

II. Rights of Individuals

Do I have rights under the federal privacy standards? Yes. Your rights to information under HIPAA include:

- *The right to request restrictions on the use and disclosure of your PHI.* You may request the Fund to restrict the uses and disclosures of your PHI. However, the Fund is not required to agree to your request (except that the Fund must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket). You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Fund's Privacy Official.

- *The right to receive confidential communications concerning your medical condition or treatment if you believe that disclosure of this information could endanger you.* For example, you can make a written request that the Fund send information about your medical treatment to a post office box or an address different from your home address in order to ensure that your PHI remains confidential. You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Fund's Privacy Official. The Fund will attempt to honor reasonable requests for confidential communications.

- *The right to inspect and copy your PHI.* The Fund may charge a reasonable fee for copying, assembling and mailing your requested PHI. You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual. *"Designated Record Set"* includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Fund; or other information used in whole or in part by or for the Fund to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Fund's Privacy Official. If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial,

a description of how you may appeal the Fund's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services. The Fund may charge a reasonable, cost-based fee for copying records at your request.

- *The right to receive an electronic copy of your electronic medical records.* The Fund will make every effort to provide access to PHI in the form or format you request, if it is readily producible in such form or format.

- *The right to receive notice of a breach of your unsecured PHI.*

- *The right to amend or submit corrections to your PHI.* If you believe that the information in your records is inaccurate or incomplete, you may submit a written request to correct these records. The Fund may deny your request if, for example, you do not include the reason that you wish to correct your records or if the records were not created by the Fund. You have the right to request the Fund to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set. The Fund has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. If the request is denied in whole or part, the Fund must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Such requests should be made to the Fund's Privacy Official. You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

- *The right to receive an accounting of how and to whom you're PHI has been disclosed, if it was disclosed for reasons other than payment or health care operations.* At your request, the Fund will also provide you an accounting of disclosures by the Fund of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Fund's privacy practices. In addition, the Fund need not account for certain incidental disclosures. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

- *The right to file a complaint that your privacy rights have been violated, with the Fund and with the Secretary of U.S. Department of Health & Human Services*. You will **not** be penalized or otherwise retaliated against for filing a complaint.

- *The right to receive a printed copy of this Notice.*

To exercise these rights, you may file requests with the Fund office, to the attention of the Fund's Privacy Officer, whose name, address, and telephone number appear below. The Fund office will let you know if the Fund accepts or rejects your request (and why) in writing within the time set by law.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Fund retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

III. The Fund's Duties

The Fund is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Fund's legal duties and privacy practices. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Fund still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner. If the revised version of this Notice is posted on the Fund's website you will also receive a copy of the Notice, or information about any material change and how to receive a copy of the Notice in the Fund's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Fund's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Fund or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Fund will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Fund's compliance with legal regulations.

De-Identified Information
This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information
The Fund may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Fund. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach
The Fund is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Fund will notify affected individuals of the breach.

IV. Your Right to File a Complaint With the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Fund. Such complaints should be made to the Fund's Privacy Official. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Fund will not retaliate against you for filing a complaint.

V. Whom to Contact at the Fund for More Information

The Fund has designated Stephen Barnett as the Privacy Officer. If you wish to file an authorization, request information to which you have a right, or file a complaint with the Fund, or if you have any questions regarding this Notice, you should address them to:

Mr. Stephen Barnett
HIPAA Privacy Officer
137 Gazza Blvd.
Farmingdale, NY 11735

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Fund's Privacy Official.

Conclusion

PHI use and disclosure by the Fund is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. The Fund intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

Please remember that the Fund can assess reasonable charges for copying, assembling and mailing to you any documents that you request.

OTHER BENEFITS

Depending upon your collective bargaining agreement, the following benefits may also be available to you as provided by the Plan. You must refer to your collective bargaining agreement or other agreement that governs the contributions made to this Fund on your behalf or contact the Welfare Fund Office at (631) 694-2480 ex. 2.

SUPPLEMENTAL UNEMPLOYMENT BENEFIT

The Supplemental Unemployment Benefit is designed to provide financial assistance to you and your family in time of financial need due to a lack of available covered employment. This benefit will be paid in addition to State Unemployment Benefits.

A. INITIAL ELIGIBILITY REQUIREMENTS

You satisfy the initial eligibility requirement for this benefit by working at least 800 hours of covered employment in the first eighteen-month period of your employment.

You will be eligible for this benefit on the first of the month coinciding with or next following the date in which you satisfied the above-requirements.

B. CONTINUING ELIGIBILITY REQUIREMENTS

After you have satisfied the initial eligibility requirements, you must accumulate an additional 800 hours in the 15-consecutive-month-period immediately preceding the date of your claim. You must also be receiving a State Unemployment Benefit and be unemployed but available for covered employment.

You will not be considered available for covered employment if:

- you have been suspended from the Union;
- you have transferred to another Union;
- you have withdrawn from the Union;
- the Union informs the Fund that you have not been available for covered employment; or
- you have retired.

C. APPLYING FOR YOUR BENEFIT

If you have satisfied the initial and continuing eligibility for this benefit and you wish to apply for benefit payment, you must provide a copy of your New York State Unemployment check to the Fund Office by 10:00 am on Wednesday. Your New York State Unemployment Check must be for the same week in which you are applying.

To expedite your benefit payment, please enclose the copy of your New York State Unemployment check in an envelope and write the following:

"ATTN: SUB"

Failure to follow these steps will result in forfeiture of your benefit for the week.

Eligibility is determined on a weekly basis, therefore, you must follow this application process for each week that you wish to receive a benefit payment.

D. RECEIVING YOUR BENEFIT

The Supplemental Unemployment Benefit is $150 per week for a maximum of 26 weeks within a 12-month period. The Fund Office will mail weekly checks on Thursday of each week to all participants who qualify for and have properly applied for the Supplemental Unemployment Benefit. If you wish to pick up your check rather than having it mailed, simply write the words **"PICK UP"** on the weekly copy of your New York State Unemployment check.

In any event, all checks will be mailed by 4:00 p.m. on Thursday. No checks will be held at the Fund Office beyond 4:00 p.m.

E. TERMINATION OF ELIGIBILITY

Your eligibility for this benefit will terminate when you do not work any hours of covered employment for a period of 18 consecutive months or longer or you retire. If this occurs, you must once again satisfy the initial eligibility requirements of this benefit to be eligible for this benefit.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT

Life Insurance and Accidental Death and Dismemberment Insurance (AD&D) are an important part of a solid plan of benefits. We hope these benefits help provide you piece of mind and added security when planning for your family's future.

Once you satisfy the Plan's initial eligibility requirements you will receive a booklet describing your Life and AD&D coverage as well as a beneficiary enrollment card. You may designate any person to be your beneficiary and you may change your designation (following proper Plan procedure) as often as necessary. It is important to keep your beneficiary designation up-to-date. If you have not named a beneficiary or the beneficiary you have named does not survive you, your benefit will be payable to your estate. You must contact the Fund Administrator for the proper life insurance forms.

A. LIFE INSURANCE BENEFIT

Eligible active employees and pensioners are covered for the Life Insurance Benefit. Their dependents are not. "Active" means that you must be in benefit status at time of death.

1. Active Employees. The Life Insurance Benefit provides a Death Benefit to your designated beneficiary if you die while an eligible active participant. This benefit is payable as follows:

Active participants under age 70.....$25,000
Active participants age 70 - 75 .....$16,750
Active participants age 75+ $12,500

The Life Insurance Benefit for active participants is insured through life insurance company. You will be provided with the certificate of insurance for a complete description of this benefit.

2. Retirees. The Life Insurance Benefit for retirees is provided directly from the Plan. A Death Benefit will be made to your designated beneficiary if you die while receiving a pension from the I. U. O. E. Central Pension Plan.

The amount of the retiree life insurance benefit is based upon "Life Insurance Credited Service." Life insurance credited service is earned as follows:

- Prior to January 1, 1990 - 800 or more hours of credited service earned in a plan year equals one year of life insurance credited service; and
- January 1, 1990 and after - 1,000 hours or more of credited service earned in one plan year equals one year of life insurance credited service.

Retirees with at least five years (but less than ten years) of life insurance credited service shall be provided with $2,000 of life insurance. Retirees with ten or more years of life insurance credited service are provided with an amount of life insurance equal to $200 for each credited year up to a $4,000 maximum benefit. This benefit is available as long as the retired participant is receiving medical coverage under the Local 138 Welfare Fund. There will be no life insurance benefit payable to your survivor if you die beyond your eligible coverage period under the Local 138 Welfare Fund.

B. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Active employees are eligible for the AD&D Benefit. Dependents and pensioners are not.

If you suffer the loss of life, sight, hand or foot as a result of an accident and such loss occurs within 90 days of the accident, you will be paid in accordance with the following schedule:

Loss	Active Employees		
	Under Age 70	Age 70 – 75	75+
Life	$50,000	$33,500	$25,000
One Member*	25,000	16,750	12,500
Two Members*	50,000	33,500	25,000

* A member means a hand, foot or loss of sight in one eye.

The AD&D Benefit is currently insured by Sun Life Insurance & Annuity Company. Please refer to the certificate of insurance provided by Sun Life Insurance & Annuity Company for a complete description of this benefit.

VACATION BENEFIT

The purpose of the Vacation Benefit is to make it possible for you to enjoy the healthful effects of a vacation. You are encouraged to take a vacation at a time that is beneficial to both you and your employer.

A. INTIAL & CONTINUING ELIGIBILITY REQUIREMENTS

Provided that your collective bargaining agreement determines that you are eligible for a Vacation Benefit, you will be eligible to participate in the Vacation Benefit from their date of hire and continue to be eligible as long as you work in covered employment.

B. FINANCING

Your employer is required to pay an amount which is specified through its collective bargaining agreement. The rate is currently set at $2.25 per regular rate hour and $4.50 per overtime rate hour. This payment is deducted by your employer from your net pay (after taxes) and is used to purchase special stamps.

The money for the stamps is received and held in trust by the Fund pending (a) payment of benefits; and (b) payment of administrative expenses. During this period, the money is invested and the resulting investment earnings became part of the Fund income. A dividend may be paid to participants based on interest earned on investments.

C. VACATION BENEFIT PAYMENTS

Depending on your eligibility for Vacation Benefit Payments, pursuant to your Collective Bargaining Agreement, You shall receive your Vacation Benefit on or after December 1 of each year based on the stamps redeemed by you to the Stamp Fund for the hours that you have worked during the preceding one year period from October 1 through September 30.

No employee or participant shall have the option to receive, instead of Vacation Benefits, any part of the employer payments made on his behalf.

D. DEATH BENEFIT

You may designate any person to be your beneficiary and you may change your designation (following proper Plan procedure) as often as you like. It is important to keep your beneficiary

designation up-to-date. If you have not named a beneficiary or the beneficiary you have named does not survive you, your benefit will be payable to your estate.
Your beneficiary shall receive a lump sum payment equal to the value of the stamps you had redeemed for the year for which you did not receive a benefit, less the applicable administration charge plus any interest earned.

CLAIMS PROCEDURE FOR MEDICAL BENEFITS AND OTHER BENEFITS PROVIDED BY THE PLAN

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

(a) Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless

you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

(b) Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

<u>When balance billing isn't allowed, you also have the following protections</u>

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Fund Office at (631) 694-2480, for assistance in contacting the appropriate entity responsible for enforcing the federal surprise billing protection law.

Visit HHS.gov for more information about your rights under Federal Law.

A. HOW TO SUBMIT A CLAIM FOR DIRECT PAYMENT TO A SERVICE PROVIDER

In order to submit a claim for direct payment to a service provider you must comply with the following steps:

1. Obtain a claim form from the Fund Office.

2. Fully complete the employee portion of the form. Be sure to include the employee's social security number. If you are a surviving spouse, please use your social security number on all claims.

3. Have the service provider fully complete the provider's portion of the form.

4. Send the above information to the following address:

MagnaCare
1600 Stewart Avenue
Suite 700
Westbury, NY 11590

B. HOW TO SUBMIT A CLAIM FOR REIMBURSEMENT

To submit a claim for reimbursement, follow the steps described above and attach all paid invoices. These invoices must show:

- name of the Plan;
- participant's name and social security number;
- name of patient;
- name, address and telephone number of service provider;
- diagnosis;
- type of services rendered, with diagnosis and/or procedure codes;
- date of services; and
- charges.

The employee's social security number must be on each bill or if you are a surviving spouse, your social security number must be on each bill.

C. HOW TO SUBMIT A CLAIM FOR PRESCRIPTION DRUGS

If the pharmacy is an Optum participating pharmacy and if you show your participation card at the time you have your prescription filled, the pharmacy will submit your claim for you. Presenting a prescription at a pharmacy is not a claim for benefits. Claims for long term maintenance medications must be submitted through the Optum Mail Order program described in Section III. There is no coverage for prescription drugs purchased from a non-participating pharmacy or from a participating pharmacy if you fail to show your identification card at the time you have your prescription filled.

D. HOW TO SUBMIT A CLAIM FOR SERVICES REQUIRING PRE-CERTIFICATION

If you do not follow the proper procedures for filing a pre-certification claim, and instead contact the Fund Office or MagnaCare, you will be notified of the proper procedure. This notification will be provided, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure to file the claim. Notification may be oral, unless you or your authorized representative request written notification. We will only provide this notice if you tell us your name, the specific medical condition or symptom, and the specific treatment, service, or product for which you are requesting approval.

E. HOW TO APPLY FOR OTHER BENEFITS

To apply for distribution from your account for the Supplemental Unemployment Benefit, Life and Accidental Death and Dismemberment Benefit, Scholarship Benefit, or Vacation Benefit, you should contact the Fund Office to inform them for which benefit you wish to apply. A staff member will inform you of the proof and forms (if any) that will be necessary to facilitate the distribution.

F. WHEN TO FILE YOUR CLAIM

Claims that do not require pre-certification should be filed within 90 days of the date charges were incurred. Benefits are based on the Plans' provisions at the time the charges were incurred. Charges are considered "incurred" when a treatment or care is given or a procedure performed. Claims filed later than 90 days may be declined or reduced.

G. BASIS FOR REVIEWING CLAIMS

All claims will be reviewed in accordance with the terms of the Plan and, if applicable, rules and procedures adopted by the Plan. Claim determinations will be made in a manner that consistently applies the terms of the Plan with respect to similarly situated claimants.

F. CLAIM DENIAL

In order to carry out their responsibility for interpreting the Plan and making determinations under it, the Trustees have exclusive authority and discretion to determine whether an individual is eligible for any benefits under the Plan; to determine the amount of benefits, if any, an individual is entitled to from the Plan; to interpret all of the plan's provisions and to interpret all of the terms used in the Plan. All such determinations and interpretations made by the Trustees or their designee shall be final and binding upon any individual claiming benefits under the Plan; shall be given deference in all courts of law to the greatest extent allowed by applicable law; and shall not be overturned or set aside by any court of law unless found to be arbitrary and capricious or made in bad faith. All such determinations shall be based exclusively upon clearly defined and ascertainable criteria contained in the Plan.

1. Denial of Supplemental Unemployment Benefits, Life and Accidental Death and Dismemberment Benefits, Scholarship Benefits, or Vacation Benefits. If your claim is denied, you will be advised within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan, unless the Plan Administrator determines that special circumstances require an extension of time. If the Plan Administrator determines that an extension of time for processing is required, you will receive written notice of the extension prior to the termination of the initial 90-day period. In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

2. Denial of Medical, Prescription Drug or Dental Benefits. If your claim is denied, you will be advised within a reasonable period of time, but not later than 30 days after receipt of the claim by the Plan, unless the Plan Administrator determines that matters beyond the control of the Plan require an extension of time. If the Plan Administrator determines that an extension of time is required, you will receive written notice of the extension prior to the termination of the initial 30-day period, of the circumstances requiring the extension of time and the date by which by the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

3. Special Rule for Pre-Certification Claims. If your claim for benefits requires pre-certification, you will be notified more quickly. You will be notified (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan, unless the Plan Administrator determines that matters beyond the control of the Plan require an extension of time. If the Plan Administrator determines that an extension of time is required, you will receive written notice of the extension prior to the termination of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

4. Special Rule for Urgent Care Claims. Special rules apply, if your claim for benefits requires pre-certification of treatment involving urgent care. A claim involving urgent care is a claim for benefits to which the application of the usual time periods for making pre-certification determinations could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or, in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is a claim involving urgent care will be determined by the Utilization Review Program administrator applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a physician with knowledge of your medical condition determines is a claim involving urgent care, will be treated as such.

If your claim involves urgent care, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator will notify you as soon as possible, but no later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's receipt of the specified information or, if earlier, the end of the period afforded you to provide the requested additional information.

5. Concurrent Care Decisions. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the

Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Plan Administrator will notify you of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of the determination before the benefit is reduced or terminated. Any request to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

H. CLAIM DENIAL NOTICE

If your claim is denied, you will receive written notice of such denial. The notice will set forth:

- The specific reason or reasons for the adverse determination.
- The specific Plan provisions on which the determination is based.
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures.
- If applicable, a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).
- In the case of an adverse benefit determination for medical, prescription drug or dental benefits, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that a copy thereof will be provided free of charge upon request.
- If the adverse benefit determination is based on a medical necessity, experimental treatment or similar exclusion or limitation, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, will be provided free of charge upon request.

- In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

- Further, in the case of an adverse benefit determination concerning a claim involving urgent care, a notice may be provided orally, provided that a written notification is furnished not later than 3 days later.

I. CLAIM DENIAL APPEAL PROCEDURE

You or your duly authorized representative may appeal the denial of any claim. Your appeal will receive a full and fair review. You will have the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim benefits. The review will take into account all comments, documents, records and other information that you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Appeals will be reviewed in accordance with the terms of the Plan and, if applicable, rules and procedures adopted by the Plan. Appeal determinations will be made in a manner that consistently applies the terms of the Plan with respect to similarly situated claimants.

To appeal the denial of supplemental unemployment benefits: life accidental death and dismemberment benefits, scholarship benefits, or vacation benefit, you must file your appeal in writing no later than 60 days following receipt of a notification of an adverse benefit determination.

To appeal the denial of medical, prescription drug or dental benefits, you must file your appeal in writing no later than 180 days following receipt of a notification of an adverse benefit determination. Your appeal will be considered by the Trustees (or, in the case of a claim requiring pre-certification or a claim involving urgent care for which you have requested expedited review, by a Plan official who is neither the person who made the initial determination, nor a subordinate of such person). Your appeal will be reviewed without deference to the initial adverse benefit determination. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Trustees or appropriate Plan official will consult with a health care professional who has training and experience in the field of medicine involved in the medical judgment. The medical or vocational experts whose advice obtained on behalf of the Plan in connection with your advice benefit determination will be identified without regard to whether the advice was relied upon in making the benefit determination. The health care professional engaged for purposes of a

consultation with the Trustees or appropriate Plan official will be an individual who is neither an individual who was consulted in connection with such individual.

You may request an expedited review of the denial of a claim involving urgent care. You may make such a request orally or in writing. All necessary information, including the Plan's benefit determination on review, may be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.

J. NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

The Trustees will make a determination regarding appeals for the denial of benefits (except claims requiring pre-certification or claims for urgent care) no later than the date of the Trustee's quarterly meeting immediately following the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination will be made by no later than the date of the second Trustees meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting of the Trustees following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan will provide you with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Trustees will notify you of the determination soon as possible, but not later than 5 days after the benefit determination is made.

1. Pre-certification Claims. For claims requiring pre-certification, the appropriate Plan official will notify you of the Plan's determination on review not later than 30 days after receipt by the Plan of your request for review.

2. Urgent Care Claims. For claims involving urgent care, the appropriate Plan official will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request for review.

3. Manner and Content of Notification of Benefit Determination on Review.

If your appeal is denied, you will receive written notice of such denial. The notice will set forth:

- The specific reason or reasons for the adverse determination.
- The specific Plan provisions on which the determination is based.

- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

- A statement that you may receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim benefits.

- In the case of an adverse benefit determination for medical, prescription drug or dental benefits, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that a copy thereof will be provided free of charge upon request.

- If the adverse benefit determination is based on a medical necessity, experimental treatment or similar exclusion or limitation, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided free of charge upon request.

- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

K. CALCULATING TIME PERIODS

The period of time within which a benefit determination or appeal is required to be made will begin at the time a claim or appeal is filed in accordance with the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to your failure to submit information necessary to make a determination, the period for the determination will be extended from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If, after a participant or dependent (hereinafter, "claimant") exhausts internal appeals pursuant to the Plan's claim procedures and is not satisfied with the determination made by the Fund, or if the Fund fails to respond to the appeal in accordance with the applicable regulations regarding timing, the claimant may be entitled to request an external review of the Fund's determination. The process will be available at no charge to the claimant.

If one of the above conditions is met, the claimant may request an external review of adverse benefit determinations based upon any one of the following:

- Clinical reasons;
- The exclusions for Experimental or Investigational Services or Unproven Services;
- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- As otherwise required by applicable law.

The claimant or claimant's representative may request a standard external review by sending a written request to the address set out in the determination letter. The claim (or claimant's representative) may request an expedited external review, in urgent situations as detailed below, by calling the Fund Office directly or by sending a written request to the Fund Office's address. A request must be made within four months after the date of the initial appeal decision.
An external review request should include all of the following:

- A specific request for an external review;
- The Claimant's name, address, and ID number;
- If applicable, the claimant's designated representative's name and address;
- The service that was denied; and
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). The Fund has entered into agreements with three or more IRO's that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review; and
- An expedited external review.

Standard External Review
A standard external review is comprised of all of the following:

- A preliminary review by the Fund of the request;
- A referral of the request by the Fund to the IRO; and

- A decision by the IRO.

Within the applicable timeframe after receipt of the request, the Fund will complete a preliminary review to determinate whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- Has exhausted the applicable internal appeals process; and
- Has provided all the information and forms required so that the Fund may process the request.

After the Fund completes the preliminary review, the Fund will issue a notification in writing to the claimant. If the request is eligible for external review, the Fund will assign an IRO to conduct such review. The Fund will assign requests by either rotating claims assignments among the IRO's or by using a random selection process.

The IRO will notify the claimant in writing of the claimant's eligibility and acceptance for external review. The claimant may submit in writing to the IRO within ten business days following the date of the receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by the claimant after ten business days.
The Fund will provide to the assigned IRO the documents and information considered in making the Fund's determination. The documents include:

- All relevant medical records;
- All other documents relied upon by the Fund; and
- All other information or evidence that the claimant or the claimant's Physician submitted. If there is any information or evidence that can be submitted that was not previously provided, the claimant may include this information with the external review request and the Fund will include it with the documents forwarded to the IRO.

In reaching a decision, the IO will review the claim anew and not be bound by any decisions or conclusions reached by the Fund. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and the claimant agrees). The IRO will deliver the

notice of Final External Review Decision to the claimant and the Fund, and it will include the clinical basis of the determination.

Upon receipt of a Final External Review Decision reversing the Fund's determination, the Fund will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Fund will not be obligated to provide benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances the claimant may file an expedited external review before completing the internal appeals process.

The claimant may make a written or verbal request for an expedited external review if the claimant receives either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and the claimants has filed a request for an expedited internal appeal; or

- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not be discharged from a facility.

Immediately upon receipt of the request, the Fund will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.

- Has provided all the information and forms required so that the Fund may process the request.

After the Fund completes the review, the Fund will immediately send a notice in writing to the claimant. Upon a determination that a request is eligible for expedited external review, the Fund will assign an IRO in the same manner the Fund utilizes to assign standard external reviews to IRO's. The Fund will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the fund. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to the Fund. You may contact the Fund Office for more information regarding external review rights, or if making a verbal request for an expedited external review.

L. INCOMPETENCE

In the event it is determined that a claimant is unable to care for his or her affairs because of illness, accident or incapacity, either mental or physical, payments due may, unless the claim has been made therefore by a duly appointed guardian, committee or other legal representatives, be paid to the spouse or such other object of natural bounty of the claimant or such person having care and custody of the claimant, as the Trustees will determine in their sole discretion.

M. COOPERATION

Every claimant will furnish to the Trustees all such information in writing as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan. The failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payments of benefits. The Trustees will be sole judges of the standard of proof required in any case, and they may from time to time adopt such formulas, methods and, procedures as they consider advisable.

N. CLAIM REPRESENTATIONS

The Trustees will have the right to recover any benefit payments made in reliance on any false or fraudulent statement, information or proof submitted, as well as any benefit payments made in error.

RECOVERY OF OVERPAYMENTS AND MISTAKEN PAYMENTS

In the event that you or a third party are paid benefits from the Fund in an improper amount or otherwise receive Fund assets not in compliance with the Plan (hereinafter overpayments or mistaken payments), the Fund has the right to start paying the correct benefit amount. In addition, the Trustees have the right to recover any overpayment or mistaken payment made to you or to a third party. You, the third party, or the individual or entity receiving the overpayment or mistaken payment must pay back the overpayment or mistaken payment to the Fund with interest at one percent over prime. This recovery may be made by reducing other benefit payments made to or on behalf of you or your dependents, by commencing a legal action or by any other method the Trustees determine to be appropriate. You, the third party, or other individual or entity shall reimburse the Fund for attorney's fees, paralegal fees, court costs, disbursements and any expenses incurred by the Fund in attempting to collect and in collecting the overpayment or mistaken payment of benefits. The determination as to these matters is solely made by the Trustees.

CLAIMS WHERE THIRD PARTY IS LIABLE

Note: This provision applies to all employees (and retirees) and their covered dependents, with respect to all of the benefits provided under this Plan. For the purposes of this provision, the terms "you" and "your" refer to all employees, retirees and covered dependents.

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or injury or is otherwise responsible for your medical bills. The Trustees, in their sole discretion, may determine to not provide benefits under the Plan for any participant who may have a third party responsible for the payment of benefits until a determination is made by the proper and final decision maker regarding the third party's responsibility to the participant. The rules in this section govern how the Fund pays benefits, if at all, in such situations.

These rules have two purposes. First, the rules ensure that your benefits will be paid promptly. Often, where there is a question of third-party liability, many months pass before the third party actually pays. These rules permit this Fund to pay your covered expenses until your dispute with the third party is resolved.

Second, the rules protect this Fund from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Fund must be reimbursed for the relevant benefits it has advanced to you out of any recovery whatsoever that you receive that is in any way related to the event which caused you to incur the medical expenses.

1. Rights of Subrogation and Reimbursement. If you incur covered expenses for which a third party may be liable, you are required to advise the Fund of that fact. By law, the Fund automatically acquires any and all rights that you may have against the third party.

In addition to its subrogation rights, the Fund has the rights to be reimbursed for payments made on your behalf under these circumstances. The Fund must be reimbursed from any settlement, judgment or other payment that you obtain from the liable third party, before any other expenses, including attorneys' fees, are taken out of the payment. The Fund has the right to full reimbursement even if, as a result of the Fund's reimbursement, you are not made whole. The Fund has the right to full reimbursement from any recovery you make regardless of how such recovery may be characterized, including but not limited to, as medical expenses, pain and suffering and/or lost earnings.

The Trustees may, in their sole discretion, require the execution of this Fund's lien forms by you (or your authorized representative if you are a minor or if you cannot sign) before this Fund pays you any benefits related to such expenses and before this Fund provides any documents. If the Trustees have required execution of the Fund's lien forms, no benefits will be provided unless you and your attorney (if any) sign the form. You must also notify the Fund before you retain another attorney or an additional attorney since that attorney must also execute the form. In no event shall the failure of the Trustees to require execution of the lien forms diminish or be considered a waiver of the Fund's rights of subrogation and reimbursement.

2. Rights of Future Subrogation and Reimbursement. In addition to satisfaction of the existing lien from any recovery by the participant and/or dependent, the Fund is also entitled to a future credit for future related Plan expenses equal to the net monies received by the participant and/or dependent. As such, the participant and/or the dependent must spend the net recovery on related Plan expenses until the amount of said net recovery is exhausted. It is only at that point that the participant's and/or dependent's further related Plan benefits will again be the responsibility of the Fund pursuant to the terms of the Plan. The Fund Office will determine the net monies available for a future credit.

3. **Assignment of Claim.** The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Fund. If this Fund recovers from the third party any amount in excess of the benefits paid to you, plus the expenses incurred in making the recovery, then the excess will be paid to you.

4. **Failure to Disclose.** If you fail to tell this Fund that you have a claim against a third party; if you fail to assign your claim against the third party to this Fund when required to do so (and to cooperate with the Fund's subsequent recovery efforts); if you fail to require any attorney you subsequently retain to sign the Fund's lien forms; if you and/or your attorneys fail to reimburse this Fund out of any payment you obtain from the third party; and/or if you fail to fully reimburse the Fund (out of any settlement you receive, or otherwise, even if this Fund reduces the amount of its lien or otherwise limits its rights); then you are personally liable to this Fund for the reimbursement owed to this Fund by the third party. This Fund may offset the amount you owe from any future benefit claims, or, if necessary, take legal action against you.

NO-FAULT BENEFITS

If you have a claim which involves a motor vehicle accident covered by the "no-fault" insurance law of any state, the “no-fault” insurance carrier must reimburse health care expenses first. Only when you have exhausted your health care benefits under the "no-fault" coverage will you be entitled to receive health care coverage under this Plan. If there are expenses for services which are covered under this Plan and which are not completely reimbursed by the "no-fault" carrier, this Plan will entertain claims for the difference up to the Plan maximums and subject to all the provisions hereof. No benefits will be payable under this Plan where a participant is not covered under a no-fault policy in violation of state law.

COORDINATION OF BENEFITS WITH OTHER COVERAGE

In the event you have coverage under another plan that provides health care benefits, there will be a coordination of benefit regarding the health care reimbursement of this Plan. This coordination will apply in the event a covered expense is incurred under this Plan, which also is covered under other programs. A determination will be made as to which plan is the "first" plan. The method of determining which plan is "first" is:

1. If the other plan does not have a coordination of benefits provision with regard to the particular expense, it is the first plan regardless of the following rules for such determination.

2. The plan that covers the patient as a current employee is the first plan.

3. If the patient is a dependent child of parents not separated or divorced, then the plan covering the parent whose birth date falls earlier in the calendar year pays first. If the other plan does not use the birthday rule, then the plan that covers the father as a current employee is the first plan, unless the first plan is already determined by 1 or 2.

When the parents of such dependent are separated or divorced, then the following rules apply:

- The plan that covers the parent with custody of the dependent, who has not remarried, is the first plan.

- If the parent of the dependent has remarried, the plan that covers the dependent as a dependent of the parent (or stepparent) with custody is the first plan.

- If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the dependent, the plan which covers the dependent as a dependent of the parent with such financial responsibility is the first plan.

4. If the other plan has a provision that it is always secondary, then this plan will be secondary in coordination with such plan.

5. If none of the above criteria establishes which plan is the first plan, the plan that has covered the patient the longest, continuously, in the period of coverage in which the expense is incurred is the first plan.

If this Plan is the second plan, it will pay its benefits as if there were no other such plan, except that this Plan will pay no greater part of a charge covered by this Plan and another plan(s) than that which when added to the part(s) payable by the other plan(s) equals 100% of such charge.

If you are an active employee or a dependent of an active employee under age 65, this Plan will be considered the primary plan for you even if you are eligible for Medicare by reason of disability caused by an illness other than End Stage Renal Disease.

COORDINATION OF BENEFITS WITH MEDICARE

When you become eligible for Medicare, the Plan will treat you as if you are insured under Parts A. and B. of Medicare. Therefore, we suggest that at least three months before you reach age 65, or three months before you receive your 24th Social Security disability pension payment, you contact your local Social Security Office. This is necessary in order to insure that as soon as you

are eligible, you are adequately covered by Medicare, which includes both Part A. for hospital coverage and Part B. for medical expenses.

Medicare will be considered as your primary plan unless you are an active (still working) employee at least age 65 (or a dependent at least age 65 of an active employee) in which case you may elect to make Medicare secondary for you and each person in the family who is eligible to enroll in Medicare. If you are an active employee (or dependent) at least age 65, the Plan Office will explain in detail the options available to you.

If Medicare is your primary plan, health care benefits provided by the Plan will be reduced by 1.) any amount payable under Part A or Part B of Medicare and 2.) any amount which would have been payable had the covered person enrolled in Part A and Part B.

It must be stressed that if you are a covered person nearing age 65 you may suffer a loss of benefits if you fail to enroll in Medicare because, even if you don't enroll in Medicare, claims will be paid as if you had.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a participant in the Local 138, 138A, 138B & 138C, I.U.O.E. Welfare Fund you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan participants shall be entitled to:

- **Receive Information About Your Plan and Benefits.** Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

  Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

  Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- **Continue Group Health Plan Coverage.** 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.

  Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

- **Prudent Actions by Plan Fiduciaries.** In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare 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 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 Administrator. If you have a claim for benefits which 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 Medical Child Support Order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal

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

- **Assistance with Your Questions.** If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor at:

201 Varick Street – Room746
New York, NY 10014
(212) 607-8600

or

The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor at:

200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

MISCELLANEOUS

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

Under the Genetic Information Nondiscrimination Act of 2008 (**GINA**), a group health plan or issuer generally may not request or require an individual or family member to undergo a genetic test. However, a plan or issuer may request a genetic test in connection with certain research activities so long as such activities comply with specific requirements prescribed by the United States Department of Labor. In the event any request is made for you to undergo a genetic test, the Plan is required to notify the United States Department of Labor and seek and exception to the prohibition to this rule.

NEW MENTAL HEALTH PARITY ACT (WELLSTONE-DOMENICI ACT)

Effective Date – Effective July 1, 2010, mental health benefits and substance use benefits that are provided through this Plan are subject to the New Mental Health Parity Act ("Wellston-Domenici Act")

The new law requires that any group health plan that includes mental health and substance use disorder benefits along with standard medical and surgical coverage must treat them equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review. For example, a plan may not apply separate deductibles for treatment related to mental health or substance use disorders and medical or surgical benefits—they must be calculated as one limit.

Lifetime/Annual Caps -- The law already requires parity in the treatment of any lifetime and annual limits for medical/surgical and mental health coverage. This Act continues these parity requirements.

Same Treatment Requirements The Plan cannot impose treatment requirements for mental health and substance abuse benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits covered by the Plan. This means that the Plan cannot impose limits on the number of visits, days of coverage, or similar limits on scope or duration of mental health or substance abuse treatment that are more restrictive than the most common or frequent type of treatment limit or requirement for medical/surgical benefits.

Out-of-Network Providers – In addition, if the Plan provides out-of-network coverage for medical/surgical benefits the Plan must also provide out-of network coverage for mental health and substance abuse benefits.

TECHNICAL DETAILS

(As required by the Employee Retirement Income Security Act of 1974)

1. **PLAN NAME:** Local 138, 138A, 138B & 138C International Union of Operating Engineers Welfare Plan.

2. **EDITION DATE:** This summary plan description is produced as of January 1, 2022.

3. **PLAN SPONSOR:** Board of Trustees of Local 138, 138A, 138B International Union of Operating Engineers Welfare Fund, P.O. Box 206, Farmingdale, N.Y. 11735.

4. **PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER:** 11-1628170.

5. **PLAN NUMBER:** 501 (assigned by federal government)

6. **TYPE OF PLAN:** Welfare Plan

7. **PLAN YEAR ENDS:** June 30.

8. **FUND ADMINISTRATOR.** Stephen Barnett., P.O. Box 206, Farmingdale, N.Y. 11735

9. **AGENT FOR THE SERVICE OF LEGAL PROCESS:** Archer, Byington, Glennon & Levine, LLP, 534 Broadhollow Road – Suite 430, Melville, NY 11747
   In addition to the person designated as agent of service of legal process, service of legal process may also be made upon any Plan Trustee or the Fund Administrator.

10. **TYPE OF PLAN ADMINISTRATION:** Board of Trustees.

11. **TYPE OF FUNDING:** All benefits are self-insured except life insurance for active employees, which is insured. Assets are held in trust.

12. **SOURCES OF CONTRIBUTIONS TO PLAN:** Employers required to contribute to the Local 138, 138A, 138B, 138C International Union of Operating Engineers Welfare Fund, certain funds with whom this Fund has reciprocal agreements, and, in certain circumstances, participants. A list of contributing employers may be obtained upon written request to the Fund Administration and is available for examination at the Fund Office.

13. **COLLECTIVE BARGAINING AGREEMENTS:** This Plan is maintained in accordance with a Collective Bargaining Agreement. A copy of this agreement may be obtained by you upon written request to the Fund Administrator and is available for examination by you at the Fund Office.

14. **PARTICIPATING EMPLOYERS:** You may receive from the Fund Administrator, upon written request, information as to whether a particular employer participates in the sponsorship of the Plan. If so, you may also request the employer's address.

15. **PLAN BENEFITS PROVIDED BY:** The Local 138, 138A, 138B, 138C International Union of Operating Engineers Welfare Fund.

16. NO INSURANCE UNDER THE PGBC: Since this Plan is not a defined-benefit pension plan, it does not enjoy coverage under the Pension Benefit Guaranty Corporation.

TRUSTEES: The Plan Sponsor and Fund Administrator of the Plan is the Board of Trustees

Employer Trustees

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James J Pratt III
Pratt Brothers
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APPENDIX A

Please click below for Local 138 Silver Plan Details

IUOE 138 Silver Plan Details