Heavy and General Laborers'
Local Union 472 and Local Union 172 of New Jersey
Welfare Fund
Summary Plan Description

Effective April 1, 2016

NOTICE OF GRANDFATHERED HEALTH PLAN

The Heavy and General Laborers' Local Union 472 and Local Union 172 of New Jersey Welfare Fund believes this is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (973) 589-5050. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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Se tiver qualquer deficuldade em compreender qualquer parte deste livrete, por favor dirija qualquer pergunta ao Director Geral., Heavy and General Laborers' Welfare Fund of New Jersey. Telefone (973) 589-5050. O horario do escritorio: Segunda a Sexta-feira:
9:00 a.m.-5:00 p.m.

TO ALL EMPLOYEES/PARTICIPANTS:

The Board of Trustees is pleased to provide you with this new Summary Plan Description (SPD), which describes the benefits available for you and your eligible dependents under the Plan of the Heavy and General Laborers' Local Union 472 and Local Union 172 of New Jersey Welfare Fund (the "Fund").

The Plan provides coverage that can help protect you against serious financial loss should you ever become ill or injured, which includes benefits for medical care and prescription drugs. The Plan also provides coverage for hearing, vision and dental services and supplies, as well as life insurance and accidental death and dismemberment benefits. Whether you are beginning a new job, having a child or adopting one, getting married or divorced, battling an illness or disability, or looking forward to retirement, the Plan offers health care coverage that is designed to help meet the needs of you and your family.

This SPD will show you how your benefits fit into the different stages of your life. It also explains:

- How you and your dependents become eligible for Plan benefits.
- The benefits available under the Plan.
- Coverage exclusions and limitations that exist under the Plan.
- How you can file a claim for benefits.
- Your rights and responsibilities regarding the various types of coverage.
- What happens when your coverage ends.

There is also a Glossary of terms that you can refer to, which provides definitions of certain terms used within this SPD.

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

The Plan described in this SPD is effective April 1, 2016, and replaces and supersedes all prior SPDs and announcements provided to Plan participants before April 1, 2016. We recommend that you keep this with your important papers so you can refer to it when needed. The Plan may be amended from time to time – to revise the benefits, change the eligibility for benefits, or to bring the Plan into compliance with changes in the laws. If this occurs, you will be provided with written notification explaining the change(s).

If you have any questions about your benefits or if you need a claim form, please call the Fund Office at (973) 589-5050.

Sincerely,

Board of Trustees

This SPD contains details of the benefits provided under the Heavy and General Laborers' Local Union 472 and Local Union 172 of New Jersey Welfare Fund as of April 1, 2016. The Board of Trustees reserves the right to amend, modify, or terminate the Plan at any time.

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GENERAL BENEFITS OVERVIEW

Your benefits under the Heavy and General Laborers' Local 472 and Local 172 Welfare Fund (the "Fund") are determined by the number of credit hours you work while you are an active employee (refer to page 2).

The Plan provides the following benefits:

If you are in:	You have benefits for:
Class 1 or Class 2	✧ Hospitalization/inpatient and outpatient medical care ✧ Members' Assistance Program (MAP) for inpatient Mental Health benefits ✧ Prescription drugs ✧ Vision care ✧ Hearing aids ✧ Life insurance (employees only) ✧ Accidental Death and Dismemberment (employees only)
Class 3 or Class 4	✧ Hospitalization/inpatient and outpatient medical care ✧ Members' Assistance Program (MAP) for Mental Health benefits ✧ Prescription drugs ✧ Vision care ✧ Hearing aids ✧ Life insurance (employees only) ✧ Accidental Death and Dismemberment (employees only)
Class 5	✧ All benefits in Classes 1, 2, 3, and 4 ✧ Substance Use Disorder benefits ✧ Dental care

ELIGIBILITY FOR COVERAGE

INITIAL EMPLOYEE ELIGIBILITY

You first become eligible for benefits on the first day of a month:

- After you work at least 1,000 credit hours within a 12-month period; and
- On which you are available for work (for reasons other than those related to a health factor) with a Contributing Employer. According to established Plan rules, the Fund's Board of Trustees will determine your availability for work.

Credit hours are the hours you work for Contributing Employers that are required to contribute to the Fund.

When Your Coverage Begins

When you are first eligible for benefits, you will be eligible for Class 1 benefits for 12 months, starting from the first month you become eligible, **provided you are actively available for work (unless unavailable for reasons related to health factors due to illness or injury) with a Contributing Employer**. If you are absent from work or not available for work on the day that benefits are to begin for reasons related to health factors (e.g., due to illness or injury), coverage will begin when you are initially eligible.

Continuing Your Eligibility

The day you become eligible for benefits establishes your "anniversary date" (the month and the day). After you first become eligible for benefits, the number of credit hours you work in your "anniversary year" will determine which Class of benefits you will receive. Your "anniversary year" is the year (12-month period) that begins on your anniversary date and ends the following year on the day before your anniversary date. In order to continue coverage, you must work a minimum of 1,000 credit hours during any anniversary year and be actively available for work with a Contributing Employer. Your availability for work will be determined by the Board of Trustees, in accordance with established rules. This provision does not apply if you are not available for work with a Contributing Employer for reasons related to health factors (e.g., due to illness or injury).

Credit Hours and Class of Benefit

Credit hours are accumulated annually between anniversary dates. The Class you fall within depends on how many hours you work in one or more years, as shown in the following chart:

If you work this number of credit hours:	You are eligible for benefits in this Class for 12 months following the month in which you work the necessary hours, provided you are actively available for work with a Contributing Employer:
At least 1,000 hours in the previous 12 months	Class 1
At least 1,000 in each of the 2 previous 12 months	Class 2
At least 3,000 within the previous 36 months (must establish Class 2 coverage before elevating to Class 3)	Class 3
At least 4,000 within the previous 48 months	Class 4
At least 5,000 within the previous 60 months	Class 5

If You Become Disabled

In the event you become disabled, you will continue to earn credit hours for each month while you are disabled. You will earn credit hours until the earlier of:

- Thirty (30) months;
- The month you become eligible for Medicare; or
- The month after you are no longer disabled, as defined in the Glossary on page 150 (refer to the definition of "Total Disability, Totally Disabled").

You will earn 84 credit hours for each month of disability. You must submit proof of your disability in order to receive credit hours. You may submit your benefit pay stubs or an abstract from the state of New Jersey, Workers' Compensation remittances, or proof of Social Security Disability payments as proof of disability. You must continue to submit such proof for each month you remain disabled. No credit will be granted without the necessary proof.

When Your Coverage Ends

Your eligibility for coverage under the Plan will end on the earlier of the date:

- ✧ You are unavailable to work with a Contributing Employer (except for reasons related to a health factor as described earlier in this section);
- ✧ A six-month period has elapsed in which no credit hours have been reported;
- ✧ The last day of the 12-month period in which you do not earn at least the minimum number of credited hours as described above;
- ✧ The Fund no longer provides benefits for your Class;
- ✧ You enter military service (except as described on page 26); or
- ✧ You become eligible for Medicare, if you are earning disability credit hours;
- ✧ The Fund is terminated.

Reinstating Your Coverage

If your eligibility for coverage ends, all of your benefits may be reinstated at the Class level you were eligible for when you lost eligibility if:

- ✧ You return to work within 12 months of the date your coverage ends; and
- ✧ You complete 1,000 hours in covered employment within 12 months of the date you return to work.

If you do not return to work within the time specified above, you will be considered a new employee for benefits purposes and it will be necessary for you to again fulfill the eligibility requirements stated on page 2.

If, during the time you were gone, you were covered by a fund that has a reciprocal agreement with this Fund, you do not need to return to work within 12 months. However, you do need to complete at least 1,000 hours in covered employment with this Fund within a 12-month period before you again become eligible for benefits.

DEPENDENT ELIGIBILITY

Coverage for your dependents begins when yours does, as long as you have enrolled them for coverage within 30 days of your effective date. See page 10 for a description of enrollment procedures and required documentation.

Your eligible dependents include:

- ✧ Your legal spouse or spousal equivalent. The Plan recognizes an employee's civil union partner as a "***spousal equivalent***." To qualify as a spousal equivalent, the relationship must have been entered into in a state that licenses or registers civil unions and the State of New Jersey must recognize the relationship as equal to a New Jersey civil union. The relationship does not have to be recognized and sanctioned by the state where the employee and partner reside. The term "***spouse***" or "***surviving spouse***" means an individual who is legally married to you and who is treated as a spouse under Federal law (including legal same sex marriages).
- ✧ Any of your children listed below who are under the age of 26 (until the end of the month in which the child turns 26), whether married or unmarried, including your:
  - Son or daughter;
  - Stepson or stepdaughter;
  - Legally adopted child or child placed for adoption. A child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. However, if a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child; and
  - Child named as an "alternate recipient" under a Qualified Medical Child Support Order (QMCSO), which is defined in the Glossary on page 147.
- ✧ An unmarried child, over the age of 26, who is totally and permanently disabled and incapable of self-sustaining employment by reason of the disability and who remain dependent on you for support. The incapacity must have started before the child reached age 19, must be certified by a doctor, and may have to be re-certified periodically. You must submit written proof of the disability to the Fund Office 31 days before the date the disabled child attains the age at which coverage would end. Coverage under this provision will end if the dependent child marries, becomes capable of self-sustaining employment, or is otherwise no longer chiefly dependent on you for economic support and maintenance.

Information on coverage criteria and required documentation begins on page 10.

In addition to the dependent children previously listed, the following individuals are eligible for coverage under the Plan:

- ✧ An unmarried individual under age 19 for whom you are the legal guardian under a court order and who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the Internal Revenue Code Sections 152(c)or 152(d), ***or***, who will be claimed as a dependent on your tax return for each Plan year that coverage is provided;
- ✧ A grandchild (including a step-grandchild) up to the age of nineteen (19), provided that:
  - You have legal custody of such grandchild pursuant to a court order;
  - Such grandchild resides permanently with you in your household;
  - If of school age, the child is enrolled in and attends a public school within your residential district (or a private school outside of your residential district for which you pay the tuition and other costs incidental to such school); and
  - You contribute over fifty percent (50%) of the child's financial support.

  No such grandchild will be enrolled as an eligible dependent until the Plan has been provided with a court order granting custody of the child to you.

When Your Dependent's Coverage Ends

Your dependent's coverage will end on the earliest of:

- ✧ The date your coverage ends;
- ✧ For your spouse or spousal equivalent:
  - The date your spouse or spousal equivalent enters the Armed Forces on a full-time active basis
  - For your spouse, the date you and your spouse divorce or are legally separated;
  - For your spousal equivalent, the date you and your spousal equivalent terminate your civil union;
- ✧ For your dependent children, the end of the month in which they no longer meet the definition of dependent child(ren), which includes:
  - The last day of the month the child reaches age 26;
  - The date a disabled child is capable of self-sustaining employment or is otherwise no longer chiefly dependent upon you for economic support and maintenance;
  - For dependents under a QMCSO: The expiration of the period of coverage stated in an applicable QMCSO;
  - The date of the dependent's death; or

- The date the Fund is terminated or no longer provides dependent coverage.

In the Event of Your Death

In the event of your death as an active Participant, your surviving spouse, spousal equivalent or dependents should contact the Fund Office. Your surviving eligible dependents will continue to be covered under the Plan, at no cost to them, for a period of one year from your date of death. After that year, your surviving spouse or dependent children may elect to continue coverage even longer by electing COBRA Continuation Coverage and paying the required premiums. Spousal equivalents are not eligible for COBRA Continuation Coverage.

RETIREE ELIGIBILITY

You are eligible for retiree coverage when you meet the following eligibility requirements:

- ✧ You retire with a minimum of 15 years of regular or vested credited service from the Heavy and General Laborers' Local Unions 472 and 172 Pension Fund of New Jersey; and
- ✧ You are eligible for Welfare Fund benefits on the date you are scheduled to retire.

Important: If you are eligible for Medicare Part B coverage due to age or disability, you must enroll and pay the Medicare premiums and deductibles. If you do not enroll, the Plan will pay only 20% of the eligible allowance for health care services.

Eligibility and Coverage for Dependents of Retirees

If you are a retiree, the Plan covers your spouse and dependent children (if you are married and have dependent children) on the effective date of your retiree coverage. Eligible dependents that are enrolled in the Plan at the time of your retirement will still be subject to the Coordination of Benefits rules enforced by the Plan (refer to the Coordination of Benefits section, beginning on page 100).

If after you retire from the Pension Fund you are receiving Plan benefits from the Welfare Fund and you marry or have a child, your spouse and child will be covered for all health benefits for which you were eligible at the time of your retirement, effective the first day of the month after documentation is received by the Fund Office.

Retiree Benefits

When you retire, you and your dependents are eligible for the same Plan benefits that you were eligible for at the time you retire. This means that:

- ✧ If you were eligible for Class 1 or Class 2 benefits when you retired, you and your eligible dependents will be eligible for Class 1 or Class 2 benefits during your retirement.
- ✧ If you were eligible for Class 3, Class 4 or Class 5 benefits when you retired, you and your eligible dependents will be eligible for those same benefits during your retirement.
- ✧ If you are a retiree or the dependent of a retiree who is eligible for Medicare, this Plan supplements your Medicare benefits. Refer to the information beginning on page 108 for details on how this Plan coordinates with Medicare when you are retired.

Cost of Retiree Coverage

If you have 15 pension credit years of service but less than 20 pension credit years of service, you will pay a premium equal to 20% of the COBRA Continuation Coverage rate. Premium amounts change each year based on the amount of the COBRA rate. Contact the Fund Office to find out the current COBRA rate.

If you have 20 or more pension credit years of service, you do not have to pay premiums for these retiree benefits.

Important: If you are receiving a pension from the Local 472/172 Pension Plan and you become employed by an employer who provides a health plan, you must enroll in that plan and the Heavy & General Laborers Welfare Plan will be secondary to that plan (or third if you are Medicare-eligible). This Plan will pay only after your employer's plan, pursuant to the Coordination of Benefit rules beginning on page 100.

If you become employed after you retire, contact the Fund Office immediately in order to ensure that you comply with all of the rules of the Laborers Pension and Welfare Plans.

RESCISSION OF COVERAGE

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that the cancellation will be effective back to the time you should not have been covered by the Plan. The Plan may rescind your coverage for fraud or intentional misrepresentation of a material fact, or due to non-payment of premiums (including COBRA premiums). For rescissions that involve fraud or intentional misrepresentation of material fact, you will be provided with 30 days advance written notice and you will have the opportunity to appeal under the procedures set forth in the Claims and Appeals section of this SPD.

Failure to provide complete and accurate information to the Fund Office in a timely manner may constitute intentional misrepresentation of material fact to the Plan.

ENROLLING FOR COVERAGE

You (the employee) are automatically enrolled for coverage when you first become eligible for benefits. However, the Fund Office will still send you an enrollment questionnaire. You should complete the enrollment questionnaire, including the beneficiary designation, and return it to the Fund Office to ensure the Fund has the proper information on file for you. If you have eligible dependents, you should enroll them when you are first eligible in order for them to be covered immediately. If you acquire a new dependent after you are initially eligible for benefits, you can enroll your new dependent when you add him or her as described in the "Special Enrollment" section that follows. When you first enroll or add a new dependent for coverage, you must provide the Fund Office with proof of dependent status.

DEPENDENT ENROLLMENT

In order for your dependents to be eligible for benefits, you must enroll them in the Plan. Contact the Fund Office for the necessary enrollment form. You should enroll your dependents as soon as possible because claims ***will not*** be payable for your dependents until the Fund Office receives the enrollment material. If you do not enroll your dependents within 30 days of your effective date of coverage, you may enroll them later, at any time. However, their coverage will then be effective the first of the month following the date the Fund Office receives your completed enrollment materials (including the necessary proof listed below), not on the date of your initial eligibility.

If your dependent is your:	You should send the Fund Office:
Spouse (or spousal equivalent)	A marriage certificate or civil union certificate.
Child	A birth certificate showing you as the biological parent or hospital record pending receipt of a birth certificate.
Adopted child or a child placed with you for adoption	A birth certificate and court order signed by the judge showing you have adopted or intend to adopt the child.
Stepchild	A certified birth certificate showing your spouse as the biological/adoptive parent, a

	marriage certificate between you and the child's parent, and a joint tax return. A copy of the divorce decree between the other biological parent (if applicable).
Child enrolled pursuant to a QMCSO	A valid QMCSO.
Disabled dependent child	A current written statement from the child's physician, including the diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically disabled (as defined in the Glossary on page 140) and is incapable of self-sustaining employment as a result of the disability, as well as being dependent chiefly on you and/or your spouse for support and maintenance. The Plan may require you to show proof of initial and ongoing disability and proof that the child meets the Plan's definition of a dependent child. In addition, if your child is age 26 or older and disabled, you will need to submit proof of your child's disability 31 days before his/her scheduled coverage termination date.
Grandchild (or step-grandchild) or a child for whom you have legal guardianship	The court-appointed legal guardianship documents and certified birth certificate, as well as proof of financial support. A court order indicating legal custody. In the case of a grandchild, proof that the child attends school in the school district where you live or proof of tuition.

SPECIAL ENROLLMENT

If you are married, enter into a civil union, or if you have any children by birth, adoption or placement for adoption, and you are eligible for benefits, you may enroll your newly acquired spouse, spousal equivalent and/or any dependent children in this Plan. It is recommended that you request enrollment within 30 days after marriage, birth, adoption, or placement for adoption. If you do not enroll your new dependent within 30 days, you may enroll him or her later. However, coverage will not be effective until the first of the month following the date the Fund Office receives your completed enrollment form and all necessary proof, provided however upon timely receipt of proof of the birth of a newborn, coverage will be effective upon birth.

If you do not initially enroll your dependents in this Plan (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll them in this Plan later if they lose eligibility for that other coverage (or if the employer stops contributing towards your dependents' other coverage). It is recommended that you request enrollment within 30 days after the loss of other coverage. If you do not enroll your dependents within 30 days, you may enroll him or her later but coverage will not be effective until the first of the month following the date the Fund Office receives your completed enrollment form and all necessary proof. To request special enrollment or obtain more information, contact the Fund Office.

Start of Coverage Following Special Enrollment

Individuals enrolled during special enrollment have the same benefit options and enrollment requirements as other similarly situated individuals.

Your newborn dependent child will be covered from the date of birth, provided you enroll him or her within 30 days of the date of birth. Adopted newborns are covered from the date of birth, provided they are placed for adoption with you no later than 30 days after they are born and you properly enroll them. Coverage for a newly adopted child or a child placed with you for adoption who is enrolled more than 30 days after the birth but within 30 days of the adoption or placement for adoption will become effective as of the date of the adoption or placement for adoption, whichever is first.

Coverage for your spouse or spousal equivalent becomes effective as of the date of the marriage or civil union, provided you enroll him or her within 30 days of your marriage.

If you do not enroll your newly acquired dependents within the necessary time frame, you may enroll them at a later time. However, their coverage will be effective the first of the month following the date of enrollment and not to the date of initial eligibility.

MEDICAID OR STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

You may enroll your dependents in this Plan if they have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and they lose eligibility for that coverage. You may also enroll your dependents in this Plan if they become eligible for a premium assistance program through Medicaid or CHIP. You should request enrollment within 60 days after the Medicaid or CHIP coverage ends or your dependents are determined to be eligible for a premium assistance program.

If you do not enroll your dependents within the necessary time frames, you may enroll them at a later time. However, their coverage will not be effective until the first of the month following the date the Fund Office receives your completed enrollment form and all necessary proof.

DECLINING VISION AND/OR DENTAL BENEFITS

There is no option to decline (opt-out of) coverage provided by this Plan. However, in accordance with Health Reform regulations, you do have the option to decline the Plan's Dental and/or Vision benefits. If you wish to decline Dental and/or Vision benefits, contact the Fund Office. If you decline Dental and/or Vision benefits, you may re-enroll for such coverage at any time by contacting the Fund Office. Changes to your enrollment in Dental and/or Vision benefits will be effective the first of the month following the month in which you re-elected coverage.

CHANGE IN STATUS EVENTS

In addition to information you must furnish the Fund Office to initially enroll a dependent, you or your covered dependents **MUST** also furnish the Fund Office with any information that may affect your eligibility for coverage under the Plan or the Fund's ability to properly administer your benefits.

For instance, when you experience a change in family status, you should notify the Fund Office of such an event and request the appropriate enrollment form. It's important that you return the completed form to the Fund Office because it helps ensure that the Fund Office has your correct

information on file. It also enables the Fund Office to keep updated information about whether you or your dependents have other benefit coverage. This information helps in processing your claims quickly and accurately. In addition, late notifications may affect your dependent's eligibility for COBRA Continuation Coverage.

You should inform the Fund Office within 30 days (but not later than 60 days) if you or any of your dependents covered by the Plan, as applicable, experience one of the following events:

- Change of name;
- Change of address;
- Marriage, legal separation, divorce, civil union termination or death (including a spouse, spousal equivalent or dependent child, as applicable). If in the event of a divorce or termination of civil union you do not contact the Fund Office, you will be liable for any expenses paid out by the Fund on behalf of your former spouse or spousal equivalent;
- Birth, adoption, placement for adoption or QMCSO of a child; or if
- The status of your dependent child changes due to, but not limited to:
    - The child reaching the Plan's limiting age;
    - The existence of any physical or mental handicap;
    - Enrollment in or cessation of Medicare coverage;
    - The award or termination of Social Security Disability benefits; and
    - Existence of other medical or dental coverage.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) (SPECIAL RULE FOR ENROLLMENT)

According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;

- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the plan to provide any type or form of benefit or any benefit option that the plan does not otherwise provide, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

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

Enrollment Related to a Valid QMCSO

If the Plan has determined that an order is a valid QMCSO, it will accept enrollment of the alternate recipient as of the earliest possible date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions. The Plan will accept a special enrollment of the alternate recipient specified by the QMCSO from either the employee or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified on the QMCSO or if not specified, the first day of the month after the special enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, including any limits on selection of provider and requirements for authorization of services, as permitted by applicable law.

Termination of Coverage

Generally, coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other dependent children. This includes termination of coverage for failure to pay any required contributions. When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage. Refer to the COBRA section, beginning on page 17, for more information.

Additional Information

You may obtain information and/or a copy of the Plan's QMCSO procedures, free of charge, by contacting the Fund Office.

CONTINUATION OF COVERAGE AND LEAVES OF ABSENCE

COBRA CONTINUATION OF COVERAGE

The federal law, Comprehensive Omnibus Budget Reconciliation Act (called COBRA), requires that plans, such as this Plan, offers eligible employees and their eligible dependents an opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law). Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Under the law, a Qualified Beneficiary is any eligible employee or retiree or the spouse or eligible dependent of an employee or retiree who was covered by the Plan when a Qualifying Event occurs, and who is, therefore, entitled to elect COBRA Continuation Coverage. A child who becomes an eligible child by birth, adoption or placement for adoption with the eligible employee or retiree during a period of COBRA Continuation Coverage is also a Qualified Beneficiary. A person who becomes the new spouse of an existing COBRA participant during a period of COBRA Continuation Coverage is not a Qualified Beneficiary.

Qualified Beneficiaries are entitled to the same special enrollment rights as eligible employees. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are shown in the chart below) occur, and, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. A Qualifying Event triggers the opportunity to elect COBRA when the Covered Individual **LOSES** health care coverage under this Plan as a result of the Qualifying Event. If a Covered Individual has a Qualifying Event but does not lose health care coverage under this Plan, (e.g., the employee's hours are reduced, but not enough to terminate coverage) then COBRA is not yet offered.

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

COBRA Qualifying Events

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event. The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date of the loss of Plan coverage. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (as described in below). The maximum period of COBRA coverage may be cut short for the reasons described in the section on “Early Termination of COBRA Continuation Coverage” that appears later in this section.

Special Note for Retiring Employees: If you are eligible for retiree medical coverage from the Fund, please be aware that when you retire, you have the option of electing COBRA instead of retiree medical coverage. If you do not elect COBRA when you retire within the time frames specified in the COBRA Election Notice, you will no longer have any rights to COBRA, even when you lose your retiree medical coverage. If your spouse and/or dependent child(ren) who are covered under the retiree coverage experience a COBRA Qualifying Event while receiving retiree coverage (for example, if you die or get divorced), they will be entitled to continue the retiree coverage in accordance with COBRA for a period of up to 36 months from the date of the loss of retiree coverage.

If you lose coverage because (a “qualifying event”):	These individuals would be eligible for COBRA coverage:	For up to:
Your employment terminates*	You and your covered spouse and children	18 months**
Your working hours are reduced	You and your covered spouse and children	18 months**
You die	Your covered spouse and children	36 months
You divorce or legally separate	Your covered spouse and step-children	36 months
Your dependent child no longer qualifies as an eligible dependent	Your child	36 months
You become entitled to Medicare	Your covered spouse and children	36 months

* For any reason other than gross misconduct.

** **Coverage continues for 29 months.** If your employment ends due to your termination of employment or reduction in hours, and at that time, or within 60 days of the event, you or one of your eligible dependents is Totally Disabled (as determined by Social Security), coverage may continue for an additional 11 months, for a total of 29 months. To continue coverage for an additional 11 months, you must notify the Fund Office of your determination of Total Disability by the Social Security Administration. The self-payment for the additional 11 months will be 150% of the self-payment for the first 18 months.

COBRA Administrator

The Fund Office is responsible for administering COBRA Continuation Coverage. In order to protect your family's rights, you should always keep the Fund Office informed of any changes in addresses for you or any of your family members or any changes in your family's status.

When Your Employer Will Notify the Fund Office

Contributing Employers should notify the Fund Office of an employee's termination of employment, reduction in hours, death, or entitlement to Medicare. However, you or your family should also promptly notify the Fund Office in writing if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in your employer providing the notification.

When You Should Notify the Fund Office

In order to have the chance to elect COBRA after a divorce, legal separation, or when a child ceases to be a "dependent child" under the Plan, you and/or a family member **MUST** notify the Fund Office in writing within 60 days of the later of the date the qualifying event or the date of the loss of coverage that results from the event. Notices should be sent to:

Heavy and General Laborers' Local Union 472 and Local Union 172
Welfare Fund of New Jersey
700 Raymond Boulevard
Newark, NJ 07105
Attn: COBRA Department

Important. If such a notice is not received by the Fund Office within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage and coverage under this Plan will terminate.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a qualifying event but determines that an individual is not entitled to the requested COBRA coverage, the Fund Office will send the individual an explanation indicating why COBRA coverage is not available. The notice will be sent according to the same time frame as a COBRA election notice.

How to Elect COBRA

When your employment terminates or your hours are reduced so that you are no longer entitled to coverage under the Plan, or when the Fund Office is notified on a timely basis that you died, divorced, became entitled to Medicare, or that a dependent child lost dependent status, the Fund Office will give you and/or your covered dependents notice of the date on which your coverage ends and the information and forms needed for you to elect COBRA. Under the law, you and/or your covered dependents will then have only 60 days from the date you or they receive that notice to apply for COBRA.

Important. If you and/or any of your covered dependents do not choose COBRA coverage within 60 days after receiving notice from the Fund Office, you and/or they will not have any group health coverage from this Plan after your coverage ends.

Each qualified beneficiary has a separate right to elect COBRA. For example, your spouse may elect COBRA even if you (the employee) do not. One member of the family may elect COBRA for other members of the family. In addition, COBRA Continuation Coverage may be elected for some family members and not others. In order to elect COBRA Continuation Coverage, the person(s) for whom COBRA is being elected must have been covered by the Plan on the day of the Qualifying Event. A parent or legal guardian may elect or reject COBRA Continuation Coverage on behalf of eligible dependents.

COBRA Continuation Coverage That Will be Provided

If you choose COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the sections entitled "Cost of COBRA Continuation Coverage" and "Paying for COBRA Coverage," below, for information about how much COBRA will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families that same change will be made in your COBRA Continuation Coverage.

Cost of COBRA Coverage

Individuals who continue full coverage under COBRA pay 102% of the Plan's cost, on an after-tax basis, except in cases of disability. See the following section entitled "Cost of COBRA Coverage in Cases of Social Security Disability" below for details.

The amount you, your covered spouse, and/or your covered dependent child(ren) must pay for COBRA will be payable monthly. The Plan is permitted to charge the full cost of coverage for similarly situated active employees and families, plus an additional 2% (for a total charge of 102%). The COBRA charge is different in cases of extended coverage due to Social Security disability.

The Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage, and of any monthly COBRA premium amount changes. The cost of COBRA may be subject to future increases during the period it remains in effect. The cost of COBRA will generally change annually.

Grace Periods

There will be an initial grace period of 45 days to pay the first amounts due starting with the date COBRA is elected. If this payment is not made when due, COBRA coverage will not take effect. After that, payments are due on the first day of each month. There will then be a grace period of 30 days to pay the monthly payments. **If payment of the amounts due is not made by the end of the applicable grace period, your COBRA coverage will end as of the due date. If payment is mailed, it is considered made when the payment is post-marked.**

Cost of COBRA Coverage in Cases of Social Security Disability

If the 18-month period of COBRA is extended because of disability, the Plan will charge employees and their families 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month period following the 18th month of COBRA coverage. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

Multiple Qualifying Events While Covered by COBRA

If you die, become divorced or legally separated, or your covered child ceases to be an eligible dependent under the Plan during an 18-month period of COBRA coverage, which results from loss of Plan coverage because of your termination of employment or reduction in hours, the maximum COBRA continuation period for the affected spouse and/or child is extended to 36 months from the date of your termination of employment or reduction in hours.

Example: Assume you lose your job (the first COBRA-qualifying event), and you enroll yourself and your covered spouse for COBRA coverage. If three months after your COBRA coverage begins, you and your spouse divorce and your spouse is no longer eligible for Plan coverage, your spouse can continue COBRA coverage for an additional 33 months, for a total of 36 months of COBRA coverage.

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

In no case are you entitled to COBRA for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA period on account of Social Security disability). As a result, if you experience a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

In order to extend coverage, you must notify the Fund Office in writing within 60 days of the date of the second qualifying event.

Social Security Disability Benefits with COBRA

If you, your spouse, or any of your covered dependent children are entitled to COBRA coverage for an 18-month period, that period can be extended for the covered person who is determined to be entitled to Social Security Disability Income benefits, and for any other covered family members, for up to 11 additional months (for a total of 29 months) if all of the following conditions are satisfied:

- ✧ The disability occurred on or before the start of COBRA coverage, or within the first 60 days of COBRA coverage.
- ✧ The disabled covered person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration.
- ✧ The Plan must receive notification in writing by you or by the disabled covered person or another family member that the Social Security determination was awarded:
  - No later than 60 days after it was received; and
  - Before the 18-month COBRA continuation period ends.

This extended period of COBRA coverage will end at the **earlier** of:

- ✧ The last day of the month, 30 days after Social Security has determined that you and/or your dependent(s) are no longer disabled.
- ✧ The end of 29 months from the date of the COBRA qualifying event.
- ✧ The date the disabled individual becomes entitled to Medicare.

You must notify the Plan when you are no longer disabled.

Acquiring a New Dependent(s) While Covered by COBRA

If you acquire a new dependent through marriage, birth, or placement for adoption while you are enrolled in COBRA, you may add that dependent to your coverage for the balance of your COBRA coverage period. ***For example***, if you have five months of COBRA left and you get married, you can enroll your new spouse for five months of COBRA coverage.

To enroll your new dependent for COBRA coverage, you must notify the Fund Office in writing after acquiring the new dependent. There may be a change in your COBRA premium amount in order to cover the new dependent.

If COBRA coverage ceases for you before the end of the maximum COBRA coverage period of 18, 29, or 36 months, COBRA coverage also will end for your newly added spouse. However, COBRA can continue for your newly added newborn child, adopted child or child placed with you for adoption until the end of the maximum COBRA coverage period if the required premiums are paid on time. Check with the Fund Office for more details on how long COBRA coverage can last.

Loss of Other Group Health Plan or Health Insurance Coverage

If, while you are enrolled in COBRA, your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA coverage. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA.

The loss of other coverage must be due to exhaustion of COBRA coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause.

Other coverage options besides COBRA Continuation Coverage

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

When COBRA Coverage May Be Cut Short

Once COBRA coverage has been elected, it may be cut short on the occurrence of any of the following events:

- The first day of the time period for which you don't pay the COBRA premiums within the required time period.
- The date on which the Plan is terminated.
- The date, after the date of the COBRA election, on which you or your eligible dependent(s) first become covered by another group health plan.

- The date, after the date of the COBRA election, on which you or your eligible dependent(s) first become entitled to Medicare (usually age 65).
- When active employee coverage would be terminated for cause (for example, you submit fraudulent claims to the Fund).
- When the employer that employed you prior to the qualifying event has stopped contributing to the Plan and (1) the employer establishes one or more group health plans covering a significant number of the employer's employees formerly covered under this Plan, or (2) the employer starts contributing to another multiemployer plan that is a group health plan. If this occurs, the new group health plan or multiemployer plan to which the employer contributes will have the obligation to continue your COBRA coverage.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a qualified beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the qualifying event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the qualified beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Fund Office determines that COBRA coverage will terminate early.

When COBRA Coverage Ends

Your COBRA coverage ends on the earliest of the date that:

- Any of the above-listed events occurs.
- The COBRA period (18, 29, or 36 months) ends.

For Questions About Your COBRA Rights

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

LEAVE FOR MILITARY SERVICE/UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time, provides for the temporary continuation of coverage that would otherwise end if you enlist in active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

Coverage under this Plan will terminate when you enter active duty in the uniformed services.

- If you elect USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months.
- If you go into active military service for up to 31 days, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

***The Plan will offer you USERRA continuation coverage only after you notify the Plan Administrator in writing that you have entered into active duty in the uniformed services*.** You must notify the Fund Office as soon as possible but no later than 60 days after the date on which you will lose coverage, unless it is impossible or unreasonable to give such notice. Once the Plan Administrator receives notice that you have entered into military service, the Plan will offer you (and any eligible dependents covered under the Plan on the day the leave started) the right to elect USERRA coverage. Unlike COBRA Continuation Coverage, if you do not elect USERRA for your dependents, your dependents cannot elect USERRA separately. Additionally, you (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA.

Note: USERRA is an alternative to COBRA, therefore either COBRA or USERRA coverage can be elected and the coverage will run simultaneously, not consecutively. Election of USERRA

coverage must be made during the COBRA election period and within the same time periods. Contact the Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Paying for USERRA Coverage

- If you go into active military service for less than 31 days, you (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period.
- If you elect USERRA temporary continuation coverage, you (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months from the date you lose coverage by making monthly self-payments. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage.
- USERRA allows you to apply your accumulated eligibility under this Plan toward the cost of continuation coverage in lieu of paying for the USERRA continuation coverage. When your accumulated eligibility is exhausted, you may pay for USERRA coverage by making monthly self-payments. If you do not want to use your accumulated eligibility to pay for USERRA coverage, you can choose to freeze your accumulated eligibility and instead proceed to pay for USERRA coverage under the self-pay rules of this Plan.
- In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This Plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice.

When You Are Discharged From the Armed Forces

When you are discharged from military service (not less than honorably), your eligibility for Plan benefits will be reinstated on the day you return to work, provided you return to employment within:

- 90 days from the date of discharge from the military, if you served in the military for more than 180 days; or

- 14 days from the date of discharge, if you served in the military for 31 days or more but less than 180 days; or
- At the beginning of the first full regularly scheduled working period, on the first calendar day following your discharge (allowing eight hours for travel), if you served in the military for less than 31 days.

If you are hospitalized or convalescing from an injury caused during active duty, the aforementioned time limits are extended up to two years.

You must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, your coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had your coverage not ended. In addition, your coverage will be subject to all Plan benefit maximums and visit limits (e.g. for acupuncture, chiropractic treatment) that were incurred prior to your leave of absence.

If you have any questions about taking a leave of absence, please speak directly with your employer. If you have any questions about how a leave of absence affects your coverage, please contact the Plan Administrator. Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA), 29 USC §2601 et seq., provides that if you work for an employer covered by that Act, you are entitled to unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care for a spouse, child or parent who is seriously ill, or for your own illness. In general, the employers covered by the FMLA are those who employ 50 or more employees for each working day during each of twenty or more calendar weeks in the current or preceding calendar year. If you are taking FMLA leave that has been approved by your employer, your employer is responsible for making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility. To find out more about family or medical leave and the terms on which you may be entitled to it, contact your employer.

Of course, any changes in this Plan's terms, rules or practices that go into effect while you are away on leave will apply to you and your dependents, the same as to active employees and their dependents. If you do not return to covered employment after your leave ends, you are entitled to COBRA Continuation Coverage when your leave ends. Call your employer to determine whether you are eligible for FMLA leave. Then call the Fund Office to learn more about your coverage during FMLA leave.

YOUR HEALTH BENEFITS

HOW THE MEDICAL PROGRAM WORKS

The medical program pays benefits for a wide range of services and supplies that are Medically Necessary to treat illness and/or injury, including doctors' charges, diagnostic testing, hospital charges, and surgery.

Eligible Medical Expenses

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called "eligible medical expenses." Eligible medical expenses are determined by the Plan Administrator or its designee, and are limited to those that are:

- "Medically Necessary," but only to the extent that the charges are "Allowed Charges" (as those terms are defined in the definition section of this document); and
- Not services or supplies that are excluded from coverage (as provided in the Exclusions section of this document); and
- Not services or supplies in excess of any Plan maximums as shown in the ***Schedule of Benefits***; and
- For the diagnosis or treatment of an injury or illness (except for the annual physical that is shown in the ***Schedule of Benefits***).

Generally, the Plan will not reimburse you for all eligible medical expenses. In most instances, you have to satisfy a deductible, and/or pay coinsurance or a co-payment toward the amount of eligible medical expenses that you incur.

Annual Deductible

Each calendar year, **you** have to pay 100% of your covered medical expenses, up to a dollar limit, before the Plan begins to pay benefits. This limit is called the "deductible." The deductible applies to each covered person each year. A separate deductible applies for services received from PPO/in-network providers and non-PPO providers.

The Plan has an annual family deductible that limits how much you have to pay if several family members are covered under the Plan. In order to meet the family deductible, at least one family member must satisfy his or her individual deductible limit. Any and all expenses incurred by the remaining covered family members are added to reach the family deductible limit.

The specific deductibles that apply for each Class are outlined in the ***Schedule of Benefits***.

Example: Here's how it works for a family with a $250 per person, $350 per family in-network PPO deductible:

Covered Medical Expenses Applied to the Family Deductible	
John	$250
Mary	$ 50
Beth	$ 25
Joe	$ 25
Total	**$350**

As a family, after at least one person has satisfied the $250 individual in-network PPO deductible and the combined covered in-network PPO medical expenses reach the $350 family in-network PPO deductible maximum during a calendar year, the Plan begins paying benefits for additional covered in-network PPO medical expenses you and your family incur during that same calendar year.

Coinsurance and Co-payments

Coinsurance and co-payments are the charges **you** must pay for certain covered health services.

- Coinsurance, generally expressed as a percentage, is your share of the costs of a covered service, in addition to any applicable deductible amount.
- A co-payment, usually expressed as a fixed dollar amount, is the amount you must pay for certain covered services at the time you receive that service.

The applicable coinsurance and co-payment amounts for each Class are outlined in the ***Schedule of Benefits***.

Out-of-Pocket Maximum

An out-of-pocket maximum limits the amount **you** pay in a calendar year for covered medical expenses. Once you meet the annual out-of-pocket limit, the Plan covers 100% of covered expenses for the rest of the calendar year, subject to any Plan limits.

A separate maximum applies for services you receive from PPO/ in-network providers and non-PPO/out-of-network providers.

Your deductible and co-payments do not count toward the out-of-pocket maximum. In addition, the out-of-pocket maximum does not include any expenses over the allowed amount or limited amounts specified by the Plan, any expenses for non-covered services and prescription drug benefits.

The applicable out-of-pocket maximum for each Class are outlined in the ***Schedule of Benefits***.

Your Responsibility

It is important to remember that the medical program is not designed to cover every health care expense. The Plan covers charges for eligible expenses, up to the limits and under the conditions established through the rules of the Plan. The decisions about how and when you receive medical care are up to you and your physician—not the Plan. The Plan determines how much it will pay; you and your physician must decide what medical care is best for you.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Fund has reached an agreement with a medical Preferred Provider Organization (PPO) to provide health care services to Plan employees at pre-negotiated discounted rates. Information on how to contact the PPO and locate network providers is shown on the ***Important Contact Information*** sheet provided along with this booklet. If you need another one, please contact the Fund Office.

PPO:

A PPO is a network of providers, including physicians and hospitals, who have agreed to charge negotiated rates. Since PPO providers have agreed to negotiated rates, you help control health care costs for you and the Plan when you use PPO providers.

If you use providers that participate in the PPO network (also referred to as in-network providers), you will generally receive a higher level of benefits than if you use non-PPO providers, also referred to as out-of-network providers. If you use non-network PPO providers, you will have to pay a higher annual deductible and coinsurance on the health care you receive, up to the Plan limits shown on the ***Schedule of Benefits*** for your Class. However, the choice of health care providers is always yours.

Because health care providers may be added to or removed from the PPO network during the year, you should call or visit the PPO's website to verify a provider's network status before you visit to ensure you will be able to receive a discounted price for the services you need. You may view maps and door-to-door directions to physicians and specialists when you use the PPO's provider directory, which is accessible via its website.

Using PPO Providers Saves You Money! When you use providers from the PPO network, you will get a higher level of benefits than if you use non-PPO providers because the Fund has negotiated discount rates from the PPO providers.

HOW TO HELP MINIMIZE YOUR OUT-OF-POCKET MEDICAL EXPENSES

To help minimize your out of pocket medical expenses, please remember to:

- ✧ Confirm that your provider is in the network before you make an appointment.
- ✧ Have all testing performed in a network free-standing facility rather than a hospital.
- ✧ Verify that all referrals from your provider are to other in-network providers.
- ✧ Precertify all inpatient admissions, and outpatient surgical facility services you are scheduled to receive that will be provided by non-PPO providers. See information that follows regarding precertification procedures.

COVERAGE FOR BREAST RECONSTRUCTION IN CONNECTION WITH A MASTECTOMY

If you or your eligible dependent is receiving benefits in connection with a mastectomy and you elect breast reconstruction in connection with the mastectomy, you are entitled to coverage for the following:

- ✧ Reconstruction of the breast on which the mastectomy has been performed;

- ✧ Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- ✧ Prostheses (i.e., breast implants) and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage for the mastectomy-related services or benefits required under the Women's Health and Cancer Rights Act will be subject to the same deductible, co-payment, coinsurance, and annual maximum provisions that apply to other medical or surgical benefits provided under this Plan.

COVERAGE FOR MATERNITY CARE

The Plan covers delivery and pregnancy-related treatment for female employees or spouses/spousal equivalents of employees. Dependent children are not covered for pregnancy-related treatment. Your maternity care benefits include, at a minimum, coverage for at least 48 hours after childbirth and a routine vaginal delivery.

Following a cesarean section delivery, the Plan provides coverage for a minimum of at least 96 hours. You are automatically eligible for these hospital lengths of stay following childbirth. If you require an extended hospital stay, you (or your physician) must call the Fund Office immediately to avoid any loss of benefits. Benefits for your newborn child include coverage for a minimum of at least 48 hours following birth for any delivery other than a cesarean section.

Note: Dependent children of any age are not covered for maternity care.

PRECERTIFICATION (PRE-SERVICE) REVIEW

Precertification review is a procedure, administered by the Fund Office, to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a hospital or outpatient surgery facility, and other health care services are Medically Necessary.

The following services must be precertified (pre-approved), as specified, BEFORE they are received:

<u>For All Classes</u>:

The following services must be precertified by the Fund Office:

- ✧ All non-emergency inpatient hospital admissions. ***Note:*** For pregnancy (for spouse or employee only), precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section
- ✧ Within 72-hours of an emergency inpatient hospital admission
- ✧ Surgery that is to be performed in an outpatient surgery facility
- ✧ All outpatient surgical facilities of non-PPO providers
- ✧ Skilled Nursing Care/Infusion Therapy Services
- o All Home Health Care (**Note**: home health aides are not covered)
- ✧ Hospice Care

For Class 3, Class 4 and Class 5 Employees:

The following outpatient supplies must be precertified by the Fund Office:

- ✧ Durable Medical Equipment (**Note**: DME is not covered under Classes 1 and 2)

The following services should be precertified by the Members' Assistance Program (MAP) Provider:

- ✧ Mental Health services, for inpatient admissions and outpatient facility-based treatment
- ✧ Substance Abuse services (for Class 5 employees only), for inpatient admissions and outpatient facility-based treatment

All benefits are subject to review. If you do not contact the Fund Office before you receive your care, your claim will be reviewed on a post-service basis (e.g., after you have received services) for medical necessity when the claim is received. Failure to precertify any required service and/or supplies may result in a denial or reduction in benefits if it is found that the service and/or supplies do not meet the medical necessity determination guidelines or other Plan terms. In addition, if benefits are not received at the appropriate level of care, the claim may also be denied, in whole or part, based on medical necessity.

How to Request Precertification (Pre-service Review)

It is your responsibility to assure that precertification occurs when it is required by this Plan. Any cost consequences due to a failure to precertify will be your responsibility, not the health care provider's.

To precertify services, you or your physician must call the Fund Office or the MAP (for Mental Health or Substance Abuse (Class 5 only). **Calls for elective services should be made at least seven days before the expected date of service and within 72-hours of emergency hospital admissions.** You or your physician should be prepared to provide all of the following information:

- ✧ The employee's name and patient's name;
- ✧ The employee's and patient's date of birth, address, phone number and insurance identification number;
- ✧ The physician's name, and phone number or address;
- ✧ The name of any hospital or outpatient facility or any other health care provider that will be providing services;
- ✧ The reason for the health care services or supplies; and
- ✧ The proposed date for performing the services or providing the supplies.

If your admission or service is determined not to be Medically Necessary (including the level of care that is being proposed), you and your physician will be given recommendations for alternative treatment (e.g., services may be available on an outpatient basis). You may also pursue an appeal. Refer to the "How to Claim Benefits" section beginning on page 87 for information on how to file and/or appeal a claim.

The Member's Assistance Program (MAP)

The Members' Assistance Program (MAP) is available to all Classes for Mental Health services. However, it is ONLY available for Class 5 employees and their dependents for alcohol and substance abuse-related issues. Note that use of MAP providers is voluntary. You are not required to use the MAP in order to receive treatment for your mental health (or for a substance use disorder for Class 5 employees), but you are strongly encouraged to do so in order to maximize benefits under the Plan.

The following benefits are available up to the amounts listed in the ***Schedule of Benefits***:

- **Classes 1 and 2, and Classes 3 and 4** – Inpatient and outpatient mental health benefits.
- **Class 5 only** – Inpatient and outpatient mental health and substance use disorder benefits.

The MAP is designed to provide prompt, professional assistance for participants and eligible dependents needing help with mental health and/or alcohol and substance abuse-related issues. The MAP can assist you with coordinating your care and helping you access an in-network provider, which could save you a lot in out-of-pocket costs.

When you call the MAP, a trained professional will help you identify and evaluate your problem and, if necessary, refer you to the best and most appropriate resource. Following consultation to determine your eligibility and the type of program required, a treatment center will assign the appropriate level of care and coordinate continuing care services. For more information or to schedule an appointment, contact the MAP at the phone number shown on the ***Important Contact Information*** sheet provided along with this booklet. If you need another copy, please contact the Fund Office.

All telephone calls and consultations with MAP professionals are held in the strictest confidence by the treatment facility.

While we encourage you to use the MAP when you need mental health services and/or care for alcohol and substance abuse-related issues (for Class 5 employees only), please note that you may receive such care from any provider. However, in order to maximum your benefits and keep your out-of-pocket expenses to a minimum, you should contact the MAP for assistance prior to accessing care.

CASE MANAGEMENT

Case management is a valuable feature of the Plan if you or a dependent has a catastrophic injury or serious illness. A case manager works with you and your family to manage health benefits as effectively as possible. The goal is to ensure the patient receives the level of quality care needed in the most appropriate setting so that benefits are used in the most cost efficient manner. This way the maximum benefits provided by the Plan will last as long as possible. The program is handled through the Fund Office.

After an initial screening to determine if case management is appropriate, the Fund case manager will contact the attending physician to obtain clinical data, discuss the treatment plan and obtain the physician's agreement to continue the case management process. The patient is also contacted to obtain permission to continue the program. The patient and physician are included in the decision-making process at every step and must be in agreement with any alternative treatment plan.

Whenever you or your physician believes that an illness or injury is serious or will require long-term care, call the applicable contact (shown on the ***Important Contact Information*** sheet provided along with this booklet).

Case management is appropriate for, but is not limited to, cases involving:

- ✧ High-risk infants.
- ✧ Organ transplants.
- ✧ Bone marrow transplants.
- ✧ Cancer patients with repeated admissions.
- ✧ Spinal cord injuries with paraplegia or quadriplegia.
- ✧ HIV/AIDS and ARC (AIDS related complications).
- ✧ Severe burns.
- ✧ Major head trauma, multiple trauma.
- ✧ Amputation of major body parts.
- ✧ Ventilator dependent patients.
- ✧ Cerebrovascular Accident (CVA).
- ✧ Fractured hips/major joint replacement.
- ✧ Osteomyelitis.
- ✧ Traumatic and degenerative muscular/neurological disorders.

- Amyotrophic lateral sclerosis.
- Patients who will be discharged on home IV therapy, or who require medical equipment, skilled nursing care, or physical therapy.

COVERAGE—CLASS 1 AND CLASS 2

If you are in Class 1 or Class 2, you are covered for hospital and medical benefits (including physician expenses and surgery), as well as prescription drug benefits. These benefits are payable up to the Plan limits shown in the ***Schedule of Benefits*** for Class 1 and Class 2.

Other Benefits for Class 1 and Class 2 Employees

All Class 1 and Class 2 employees and their eligible dependents are also eligible for:

- ✧ Case Management Services (see page 38).
- ✧ Vision Benefits (see page 74).

In addition, Class 1 and Class 2 employees are eligible for the following benefits:

- ✧ Hearing Aid Benefits (see page 73).
- ✧ Life Insurance Benefits (see page 79).
- ✧ Accidental Death and Dismemberment Benefits (see page 82).

Please note that benefits for physician services are only payable for in-network providers. Where available, your out-of-network benefits are limited to the maximum allowance as described in the *Schedule of Benefits.* All covered expenses are subject to the Fund's fee schedule. The following ***Schedule of Benefits*** describes the benefits provided for Class 1 and Class 2 employees.

SCHEDULE OF BENEFITS FOR CLASS 1 AND CLASS 2

Class 1 and Class 2 Coverage/Benefit Levels		
Plan Feature	**PPO Providers**	**Non-PPO Providers**
Annual Deductible	$250/Individual $350/Family	$500/Individual $1,250/Family
Out-of-Pocket Maximums	$1,000/Individual $2,000/Family	$5,000/Individual $12,500/Family
Acupuncture (not covered simultaneously with physical therapy and/or chiropractic treatment) [1]	After deductible: Plan covers 100% of the contract rate	Not covered
Plan Maximum	Up to $500 per person per year	
Allergy Treatment (Allergy Testing is not covered)	Plan covers 100% of the contract rate	Not covered
Ambulance ✧ Ground vehicle emergency transportation to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency or acute illness ✧ Medically Necessary inter-health care facility transfer (e.g. transfer from one hospital to another hospital or trip to and from one hospital to another in order to obtain a special test/procedure) ✧ Air/sea emergency transportation only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status	Plan covers 100% of the contract rate	Plan covers 70% of the Fund's fee schedule
Anesthesia (Inpatient and Outpatient) Physicians and certified Registered Nurse Anesthetists	After deductible: Plan covers 100% of the contract rate	After deductible: Plan covers 40% of the Fund's surgical fee schedule, up to a maximum of $800 per surgery
Chemotherapy or Radiation Therapy (Outpatient)	After deductible: Plan covers 100%	Not covered
Chiropractic Treatment (not covered simultaneously with physical therapy and/or acupuncture)	After deductible: Plan covers 100% of the contract rate	Not covered
Plan Maximum	12 visits per covered person per year	

Class 1 and Class 2 Coverage/Benefit Levels		
Plan Feature	**PPO Providers**	**Non-PPO Providers**
Dialysis (Outpatient) It is important that individuals with end stage kidney/renal disease (ESRD) promptly apply for Medicare coverage, regardless of age. See also the “Coordination of Benefits” section that discusses what this Plan pays when you are also Medicare eligible Inpatient benefits will be paid according to the Hospital benefit	After deductible: Plan covers 100% of the contract rate	Not covered
Doctor/Physician and other Health Care Providers Benefits are payable for professional fees when provided by a physician or other covered health care provider in an office, hospital, emergency room (ER), urgent care facility or other covered health care facility location and include: ✧ Physician (MD) ✧ Pathologist ✧ Radiologist ✧ Social Worker (MSW) ✧ Physician Assistant ✧ Nurse Practitioner ✧ Certified Nurse Midwife	***Office Visits:*** After deductible: you pay a $30 co-payment, Plan covers 100% of the contract rate	Not covered
Emergency Room Hospital emergency room (ER) facility and ancillary charges (such as lab or x-ray) performed during the emergency room visit for a medical emergency	After deductible: you pay a $75 co-payment, then Plan covers 100% of the contract rate	After deductible: Plan covers 70% of the Fund’s fee schedule
Hospice Care (see page 56 for more details)—Precertification Required	After deductible: Plan covers 100% of the contract rate	Not covered

Class 1 and Class 2 Coverage/Benefit Levels		
Plan Feature	**PPO Providers**	**Non-PPO Providers**
Hospital Facility (Inpatient) including Acute Care Hospital and Birthing Center—Precertification Required The following services are covered, if they are Medically Necessary for the diagnosis and treatment of the condition for which you are hospitalized: ✧ Semi-private room, board, general nursing services and other services and supplies normally furnished by the hospital to inpatients ✧ Private room reimbursed at semi-private room rate ✧ Hospital visits by a physician ✧ Anesthesia ✧ Oxygen ✧ Diagnostic x-ray and laboratory tests (subacute unit) ✧ Telemetry ✧ Intensive/critical care units ✧ Physical rehabilitation (includes physical, occupational, and speech therapy up to 12 days per year) ✧ Medically necessary inpatient chemotherapy, radiation therapy and dialysis ✧ Inpatient Admission for Mental Health (including Medically Necessary inpatient physician visits) ✧ Maternity Care and Routine Nursery Care (for spouse of employee only) - Precertification is only required for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section	After you pay a $250 co-payment: Plan covers 100% of the contract rate $250 co-payment applies to inpatient hospital admissions once every 180-days When you are ready to be discharged from the hospital and your condition warrants additional medical care (i.e. medical equipment, home I.V. therapy, skilled nursing care or physical therapy), you or your physician should contact the Fund Office for pre-approval with the Fund's participating provider network to reduce your out-of-pocket expense.	After deductible: Plan covers 70% of the Fund's fee schedule, up to $8,300 per confinement
Immunizations	100% of contracted rate	Not covered
Laboratory Services (Outpatient)—including technical and professional ✧ Common laboratory services include diagnostic testing related to chemistry, hematology, urinalysis, toxicology, microbiology, blood banking, anatomic pathology, surgical pathology and/or cytopathology	After deductible: Plan covers 90% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule

Class 1 and Class 2 Coverage/Benefit Levels		
Plan Feature	**PPO Providers**	**Non-PPO Providers**
Mental Health Outpatient Services ✧ ***Outpatient Office Visits*** ✧ ***Intensive Outpatient and Partial Hospitalization—Precertification Required*** Continuous course of treatment is a course of treatment in a single facility. If you transfer from one facility to another, this would be considered a new course of treatment	$30 co-payment $25 co-payment per day/visit to maximum of $250 per continuous course of treatment	Not covered After deductible: Plan covers 70% of the Fund's fee schedule, up to $3,500 per partial hospitalization/intensive outpatient continuous course of treatment
Physical Rehabilitation: Physical Therapy and Occupational Therapy (not covered simultaneously with chiropractic treatment and/or acupuncture), Speech Therapy, and Pulmonary and Cardiac Rehabilitation ✧ All therapies are limited to 12 visits per year per illness or injury ✧ If there is surgical intervention or stroke, the Fund will allow 24 post-operative or post-stroke visits ✧ Plan covers short-term active, progressive occupational, physical or speech therapy that is performed by licensed or duly qualified (licensed) therapists as ordered by a physician ✧ School-aged child must exhaust the services of the Board of Education before Plan benefits are payable	After deductible: Plan covers 100% of the contract rate	Not covered

Class 1 and Class 2 Coverage/Benefit Levels		
Plan Feature	**PPO Providers**	**Non-PPO Providers**
Prescription Drugs	**Participating Retail Pharmacy and Mail Order**	**Non-Participating Retail Pharmacy**
✧ Select Generic Drugs	Retail: $9 co-payment (30-day supply); Mail Order: $15 co-payment (90-day supply)	Retail only: $9 co-payment (30-day supply) plus difference in cost between preferred and non-preferred pharmacy
✧ Generic Drugs	Retail: $20 co-payment (30-day supply); Mail Order: $25 co-payment (90-day supply)	Retail only: $20 co-payment (30-day supply) plus difference in cost between preferred and non-preferred pharmacy
✧ Preferred Brand Name Drugs	Retail: $30 co-payment (30-day supply); Mail Order: $45 co-payment (90-day supply)	Retail only: $30 co-payment (30-day supply) plus difference in cost between preferred and non-preferred pharmacy
✧ Non-Preferred Brand Name Drugs	Retail: $45 co-payment (30-day supply); Mail Order: $65 co-payment (90-day supply)	Retail only: $45 co-payment (30-day supply) plus difference in cost between preferred and non-preferred pharmacy
Routine Physical (administrative physicals required for employment, driving, school, sports or required by law are not covered)	After deductible and $30 co-payment: Plan covers 100% of one routine physical per person per year	Not covered
Skilled Nursing, Home Care and Infusion Therapy—Precertification Required ✧ Part-time, intermittent skilled nursing care services and Medically Necessary supplies to provide home health care or home infusion services only when ordered by a doctor/physician and provided by a licensed home health care agency ✧ Home Health Aides are not covered	After deductible: Plan covers 100% of the contract rate	Not covered

Class 1 and Class 2 Coverage/Benefit Levels		
Plan Feature	**PPO Providers**	**Non-PPO Providers**
Skilled Nursing Facility (SNF) and Rehabilitation Facilities—Precertification Required ✧ A case management professional will work with the hospital discharge planner to ensure a smooth transition from the hospital to the appropriate level of care at home or to a sub-acute facility (e.g., a skilled nursing care facility or rehabilitation) ✧ Treatment for Substance Abuse is not covered	After you pay a $250 co-payment: Plan covers 100% of the contract rate The co-payment will only be applied once within a 180-day period The deductible does not apply	After deductible: Plan covers 70% of the Fund's fee schedule
***Surgeon Fees (Inpatient and Outpatient)—includes* sterilization (but not reversal)**	After deductible: Plan covers 100% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule (or Fund allowance as described below), up to a maximum of $2,000 per surgery
Surgery Facility (Outpatient)—Precertification Required ✧ Includes Ambulatory (Outpatient) Surgical Facility (e.g. surgicenter, same day surgery, outpatient surgery) ✧ Physician fees payable under the doctor/physician services benefit	After you pay a $250 co-payment: Plan covers 100% of the contract rate; deductible does not apply	After deductible: Plan covers 70% of the Fund's fee schedule, up to $3,500 per surgery
X-ray/Radiology, Nuclear Medicine and Imaging Studies (Outpatient) ✧ Plan pays for technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy ✧ Radiology refers to the branch of medicine using x-rays, radiopharmaceuticals (like radioisotopes, intravenous dye or contrast materials), magnetic resonance and ultrasound to create images (pictures) of the body that are used to help in the diagnosis and treatment of disease or injury ✧ Common radiology services include chest x-ray, abdomen/kidney x-ray, spine x-ray, CT/MRI/PET and bone scan, ultrasound, angiography, mammogram, fluoroscopy, and bone densitometry	After deductible: Plan covers 90% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule
Vision	See page 74 for details on vision benefits	

EXPENSES NOT COVERED

The Plan does not cover any other benefits for Class 1 and Class 2, except for those listed in the ***Schedule of Benefits*** for Class 1 and Class 2 employees. Refer to the "Medical Plan Exclusions" section for a list of expenses that are not covered under the Plan under any circumstances. In addition to the exclusions applicable to the Plan, the following are not covered under Class 1 and Class 2:

- Substance Use Disorders, including Emergency Room visits and prescription drugs.
- Durable Medical Equipment.
- Out-of-network physician/doctor services (except inpatient visits, as outlined in the ***Schedule of Benefits***).
- Allergy testing.
- Routine foot care.
- Nutritional and/or diabetic counseling.
- Hair prosthesis.
- Foot orthotics.
- TMJ Therapy.
- Infertility treatment.
- Vision Training.

COVERAGE—CLASS 3, CLASS 4 AND CLASS 5

If you are in Class 3, Class 4 or Class 5, you are covered under the Fund's Comprehensive Medical Benefit. The Plan covers expenses for hospitalizations, surgeries, doctor visits and other necessary health care services for you and your eligible dependents. These benefits are payable up to Plan limits shown in the ***Schedule of Benefits*** for Class 3, Class 4 and Class 5.

Other Benefits for Class 3, Class 4, and Class 5 Employees

All Class 3, Class 4 and Class 5 employees and their eligible dependents are also eligible for:

- ✧ Case Management Services (see page 38).
- ✧ Hearing Aid Benefits (see page 73).
- ✧ Vision Benefits (see page 74).

Class 3 and Class 4 employees and their eligible dependents are also eligible for:

- ✧ Assistance through a Member's Assistance Program (MAP) when they are seeking treatment for a mental health disorder (see page 36).

Class 5 employees and their eligible dependents are also eligible for:

- ✧ Dental Benefits (see page 76).
- ✧ Assistance through a Members' Assistance Program (MAP) when they are seeking treatment for alcohol and substance abuse (see page 36).

Class 3, Class 4 and Class 5 employees ONLY (and not their dependents) are eligible for:

- ✧ Life Insurance Benefits (see page 79).
- ✧ Accidental Death and Dismemberment Benefits (see page 82).

The following ***Schedule of Benefits*** describes the benefits provided for Class 3, Class 4 and Class 5 employees.

SCHEDULE OF BENEFITS FOR CLASS 3, CLASS 4 AND CLASS 5

Class 3, Class 4 and Class 5 Coverage/Benefit Levels		
Plan Feature	**PPO Providers**	**Non-PPO Providers**
Annual Deductible	$250/Individual $350/Family	$500/Individual $1,250/Family
Out-of-Pocket Maximums	$1,000/Individual $2,000/Family	$5,000/Individual $12,500/Family
Acupuncture (not covered simultaneously with physical therapy and/or chiropractic treatment)	After deductible: Plan covers 100% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule
Plan Maximum	Up to $500 per person per year	
Allergy Testing and Treatment Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast.	After deductible: Plan covers 90% of the contract rate for testing and 100% of the contract rate for treatment	After deductible: Plan covers 70% of the Fund's fee schedule
Ambulance ✧ Ground vehicle emergency transportation to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency or acute illness ✧ Medically Necessary inter-health care facility transfer (e.g., transfer from one hospital to another hospital or trip to and from one hospital to another in order to obtain a special test/procedure). The Plan does not cover transportation for a patient's convenience ✧ Air/sea emergency transportation only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status	After deductible: Plan covers 100% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule
Anesthesia (Inpatient and Outpatient) Physicians and certified Registered Nurse Anesthetists	After deductible: Plan covers 100% of the contract rate	After deductible: Plan covers 40% of the Fund's surgical fee schedule
Chemotherapy or Radiation Therapy (Outpatient)	After deductible: Plan covers 100%	After deductible: Plan covers 70% of the Fund's fee schedule
Chiropractic Treatment (not covered simultaneously with physical therapy and/or acupuncture)	After deductible: Plan covers 100% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule
Plan Maximum	Up to 12 visits per covered person per year	
Diabetic Counseling Must have diagnosis of diabetes	Plan covers at 100%	Plan covers 70% of Fund's fee schedule
Plan Maximum	Up to 8 units (15 minutes per unit)/lifetime.	

Class 3, Class 4 and Class 5 Coverage/Benefit Levels		
Plan Feature	**PPO Providers**	**Non-PPO Providers**
Dialysis (Outpatient) It is important that individuals with end stage kidney/renal disease (ESRD) promptly apply for Medicare coverage, regardless of age. See also the "Coordination of Benefits" section that discusses what this Plan pays when you are also Medicare eligible Inpatient benefits will be paid according to the hospital benefit	After deductible: Plan covers 100% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule
Doctor/Physician and other Health Care Providers Benefits are payable for professional fees when provided by a physician or other covered health care provider in an office, hospital, emergency room (ER), urgent care facility or other covered health care facility location and include: ✧ Physician (MD) ✧ Pathologist ✧ Radiologist ✧ Social Worker (MSW) ✧ Podiatrist (DPM) ✧ Physician Assistant ✧ Nurse Practitioner ✧ Certified Nurse Midwife	***Office Visits:*** After deductible and you pay a $25 co-payment: Plan covers 100% of the contract rate ***Inpatient Visits:*** After deductible: Plan covers 100% of the contract rate; no co-payment	After deductible: Plan covers 70% of the Fund's fee schedule
Durable Medical Equipment/Surgical Equipment—Precertification Required When ordered by a physician, coverage is provided for: ✧ Rental (but only up to the allowed purchase price of the durable medical equipment) ✧ Purchase of standard model ✧ Replacement of Medically Necessary durable medical equipment once every five years, only if there is a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired at a lesser expense ✧ Medically necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration Repair, adjustment or servicing of durable medical equipment is not covered	After deductible: Plan covers 100% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule

Class 3, Class 4 and Class 5 Coverage/Benefit Levels		
Plan Feature	**PPO Providers**	**Non-PPO Providers**
Emergency Room Hospital emergency room (ER) facility and ancillary charges (such as lab or x-ray) performed <u>during</u> the emergency room visit for a medical emergency	After deductible: you pay a $75 co-payment	After deductible: Plan covers 70% of the Fund's fee schedule
Hair Prosthesis (if required to replace hair lost as a result of treatment of diseases by radiation or chemicals, alopecia universalis, totalis, or alopecia areata)	After deductible: Plan covers 90%	After deductible: Plan covers 90% of the Fund's fee schedule
Plan Maximum	One purchase in a two-year period; up to $500 per person	
Hospice Care (see page 56)—Precertification Required	After deductible: Plan covers 100% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule
Hospital Facility Charge (Inpatient) including Acute Care Hospital, and Birthing Center—Precertification Required The following services are covered, if they are necessary for the diagnosis and treatment of the condition for which you are hospitalized: ✧ Semi-private room, board, general nursing services and other services and supplies normally furnished by the hospital to inpatients ✧ Private room reimbursed at semi-private room rate ✧ Hospital visits by a physician ✧ Anesthesia ✧ Oxygen ✧ Diagnostic x-ray and laboratory tests (subacute unit) ✧ Telemetry ✧ Intensive/critical care units ✧ Physical rehabilitation (includes physical, occupational, and speech therapy up to 12 days per year) ✧ Maternity Care and Routine Nursery Care (for spouse of employee only) - Precertification is only required for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section ✧ Inpatient admission for Mental Health (including Medically Necessary inpatient physician visits) ✧ Inpatient admission for substance abuse for Class 5 only (including Medically Necessary inpatient physician visits)	After you pay a $250 co-payment: Plan covers 100% of the contract rate The co-payment will only be applied once within a 180-day period The deductible does not apply When you are ready to be discharged from the hospital and your condition warrants additional medical care (i.e. medical equipment, home I.V. therapy, skilled nursing care or physical therapy), you or your physician need to contact the Fund Office for pre-approval with our participating provider network to reduce your out-of-pocket expense	After deductible: Plan covers 70% of the Fund's fee schedule

Class 3, Class 4 and Class 5 Coverage/Benefit Levels		
Plan Feature	**PPO Providers**	**Non-PPO Providers**
Immunizations	Plan covers 100% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule
***Infertility Treatment* (Employee and Spouse only)**	After deductible: Plan covers 100% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule
Plan Maximum	Up to $1,000 per person per lifetime	
Laboratory Services (Outpatient)—including technical and professional fees ✧ Common laboratory services include diagnostic testing related to chemistry, hematology, urinalysis, toxicology, microbiology, blood banking, anatomic pathology–surgical pathology and/or cytopathology	After deductible: Plan covers 90% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule
Mental Health and Substance Abuse (Substance abuse is only applicable to Class 5) Outpatient Services		
✧ Outpatient Visits	After deductible: you pay a $25 co-payment per visit	After deductible: Plan covers 70% of the Fund's fee schedule
✧ Intensive Outpatient and Partial Hospitalization - Precertification Required	After deductible: Plan covers 100% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule
Nutritional Counseling	After deductible and you pay a $25 co-payment: Plan covers up to Plan Maximum	After deductible: Plan covers 70% of the Fund's fee schedule
Plan Maximum	Up to 3 units (15 minutes per unit) per lifetime	
Organ Transplants—Precertification Required (including drugs; see page 57)	Payable according to applicable Plan provisions	After deductible: Plan covers 70% of the Fund's fee schedule
Orthotics (one pair only, when deemed Medically Necessary by the Fund)	Plan covers:	After deductible: Plan covers 70% of the Fund's fee schedule
Limitations:		
✧ For covered adult every three years	Up to $150 per orthotic or $300 per pair	
✧ For children as medically indicated	Up to $150 per orthotic or $300 per pair	

Class 3, Class 4 and Class 5 Coverage/Benefit Levels		
Plan Feature	**PPO Providers**	**Non-PPO Providers**
Physical Rehabilitation: Physical Therapy and Occupational Therapy (not covered simultaneously with chiropractic treatment and/or acupuncture), Speech Therapy, and Pulmonary and Cardiac Rehabilitation ✧ All therapies are limited to 12 visits per year per illness or injury. If there is surgical intervention or stroke, the Fund will allow 24 post-operative or post-stroke visits ✧ Plan covers short-term active, progressive occupational, physical or speech therapy that is performed by licensed or duly qualified (licensed) therapists as ordered by a physician ✧ School-aged child must exhaust the services of the Board of Education before Plan benefits are payable	After deductible: Plan covers 100% of the contract rate	Not covered
Prescription Drugs (See page 58 for details)	**Participating Retail Pharmacy and Mail Order**	**Non-Participating Retail Pharmacy**
✧ Select Generic Drugs	Retail: $4 co-payment (30-day supply); Mail Order: $10 co-payment (90-day supply)	Retail only: $4 co-payment (30-day supply) plus difference in cost between preferred and non-preferred pharmacy
✧ Generic Drugs	Retail: $15 co-payment (30-day supply); Mail Order: $20 co-payment (90-day supply)	Retail only: $15 co-payment (30-day supply) plus difference in cost between preferred and non-preferred pharmacy
✧ Preferred Brand Name Drugs	Retail: $25 co-payment (30-day supply); Mail Order: $40 co-payment (90-day supply)	Retail only: $25 co-payment (30-day supply) plus difference in cost between preferred and non-preferred pharmacy
✧ Non-Preferred Brand Name Drugs	Retail: $40 co-payment (30-day supply); Mail Order: $60 co-payment (90-day supply)	Retail only: $40 co-payment (30-day supply) plus difference in cost between preferred and non-preferred pharmacy

Class 3, Class 4 and Class 5 Coverage/Benefit Levels		
Plan Feature	**PPO Providers**	**Non-PPO Providers**
Pre-Surgical Testing (Outpatient) The Plan provides coverage for outpatient pre-surgical testing, provided the tests are: ✧ Related to the scheduled surgery ✧ Performed within seven days before the scheduled surgery ✧ Related only to a covered surgery (e.g., not for cosmetic surgery) For surgery performed in a hospital or surgical center	After deductible: Plan covers 90% of the contract rate	After deductible, Plan covers 70% of the Fund's fee schedule
Routine Physical (administrative physicals required for employment, driving, school, sports or required by law are not covered)	After deductible and you pay a $25 co-payment: Plan covers 100% of one routine physical per person per year	After deductible: Plan covers 70% of the Fund's fee schedule for one routine physical per person per year
Skilled Nursing Facility (SNF) and Rehabilitation Facilities ✧ A case management professional will work with the hospital discharge planner to ensure a smooth transition from the hospital to the appropriate level of care at home or to a sub-acute facility (e.g., a skilled nursing care facility or rehabilitation) ✧ Substance Abuse treatment is not covered for Classes 3 and 4	After you pay a $250 co-payment: Plan covers 100% of the contract rate The co-payment will only be applied once within a 180-day period The deductible does not apply	After deductible: Plan covers 70% of the Fund's fee schedule
Skilled Nursing/Home Care and Infusion Therapy—Precertification Required ✧ Part-time, intermittent skilled nursing care services and Medically Necessary supplies to provide home health care or home infusion services only when ordered by a physician or health care practitioner and provided by a licensed home health care agency ✧ Home Health Aides are not covered	After deductible: Plan covers 100% of the contract rate after $250 co-payment (inpatient only)	After deductible: Plan covers 70% of the Fund's fee schedule
Surgeon Fees (Inpatient and Outpatient) Includes sterilization (but not reversal)	After deductible: Plan covers 100% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule (or allowance as described below)
Surgery Facility (Outpatient/Ambulatory Facility)—Precertification Required ✧ Includes Ambulatory (Outpatient) Surgical Facility (e.g. surgicenter, same day surgery, outpatient surgery) ✧ Physician fees payable under the doctor/physician benefit	No deductible: After you pay a $250 co-payment*: Plan covers 100% of the contract rate *Co-payment will only be applied once within a 180 day period	After deductible: Plan covers 70% of the Fund's fee schedule, for up to $3,500 per surgery

Class 3, Class 4 and Class 5 Coverage/Benefit Levels		
Plan Feature	**PPO Providers**	**Non-PPO Providers**
TMJ Therapy Plan Maximum: Up to $1,000 per person per lifetime	After deductible: Plan covers 100% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule
X-ray/Radiology, Nuclear Medicine and Imaging Studies (Outpatient) ✧ Plan pays for technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy ✧ Radiology refers to the branch of medicine using x-rays, radiopharmaceuticals (like radioisotopes, intravenous dye or contrast materials), magnetic resonance and ultrasound to create images (pictures) of the body that are used to help in the diagnosis and treatment of disease or injury ✧ Common radiology services include chest x-ray, abdomen/kidney x-ray, spine x-ray, CT/MRI/PET and bone scan, ultrasound, angiography, mammogram, fluoroscopy, and bone densitometry	After deductible: Plan covers 90% of the contract rate	After deductible: Plan covers 70% of the Fund's fee schedule
Vision Benefits	See page 74 for details on vision benefits	

HOSPICE CARE

The Fund provides coverage for employees or/and their eligible dependents having a life expectancy of six months or less. The services must be part of a Hospice plan of care established by a physician and a Hospice Care Agency to provide palliative and supportive care to terminally ill individuals and supportive care to their families.

Care may be provided by a Medicare-certified freestanding Hospice facility, the Hospice unit of a hospital or a Hospice Care Agency. Any provider must meet licensing and certification standards required by the state in which it operates.

If Hospice care is required, contact the Fund Office, as services require case management (unless Medicare is the primary carrier, in which case the Fund follows Medicare guidelines up to Plan limits).

Hospice Expenses Covered

Covered Hospice care expenses include:

- Hospital, Hospice or convalescent facility charges for:
  - Full-time inpatient room, board and other services provided for pain control and other acute and chronic symptom management;
  - Services and supplies provided to the patient while not confined as a full-time patient; and
  - If pre-approved by the Fund Office, up to eight hours a day for part-time or intermittent nursing care provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

Medical social services provided under the direction of a physician, including:

- Assessment of the patient's social, emotional and medical needs and the home and family situation.
- Identification of community resources available to the patient.
- Assistance in helping the patient obtain the resources necessary to meet his or her assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a physician.
- Physical and occupational therapy.

- ✧ Charges by a physical or occupational therapist who is not a member of a Hospice care agency.
- ✧ Up to eight hours a day of part-time or intermittent home health aide services primarily to care for the patient.
- ✧ Medical supplies and drugs prescribed by a physician.

Hospice Expenses Not Covered

In addition to any relative expenses listed in the ***Medical Plan Exclusions*** section beginning on page 62, the following Hospice care related expenses are not covered:

- ✧ Funeral arrangements.
- ✧ Pastoral counseling.
- ✧ Financial or legal counseling, including estate planning or drafting a will.
- ✧ Home Health Aide.
- ✧ Homemaker or caretaker services not solely related to the care of the patient, including sitter or companion services for the patient or family members, transportation, housecleaning and household maintenance.
- ✧ Respite care furnished when the patient's family or caretaker cannot or will not attend to the patient's needs.

ORGAN AND BONE MARROW TRANSPLANTS

If you become a candidate for an organ or bone marrow transplant, you must notify the Fund Office. You, your doctor, or the hospital must also contact the Fund's transplant Case Manager. Refer to the ***Important Contact Information*** sheet provided by the Fund Office for contact information.

The Plan covers the following transplants:

Transplants Covered	
Bone marrow, including stem cells	Pancreas
Heart; Heart/Lung (combined)	Pancreas and kidney (combined only)
Liver	Small intestine
Lung	Circulatory assist and hepatic assist device

The Plan does not cover cornea transplants.

PRESCRIPTION DRUG BENEFITS

If you are a Class 1, 2, 3, 4, or 5 employee, you are eligible for two types of prescription drug benefits through the Fund: retail prescription drug benefits and mail order prescription drug benefits. The Heavy and General Laborers' Health Fund has established a relationship with a Pharmacy Benefit Manager (PBM) to provide drugs at reduced cost to the Fund and to employees.

Preferred Retail Pharmacy

When you have your prescriptions filled at a preferred retail pharmacy, benefits are payable for up to a 30-day supply. You are responsible for a co-payment for each prescription. The amount of the applicable co-payments is outlined in the applicable ***Schedule of Benefits***. Your co-payment depends on what medication you and your physician decide is best for your specific needs. You should present your ID card when you have prescriptions filled at a preferred retail pharmacy. Once you present your ID card, all you need to do is pay the applicable co-payment. You do not have to complete any claim forms.

Co-payments

Under this Plan, there are four tiers of co-payments: **Select Generic, Generic, Preferred *Brand, and Non-Preferred Brand***.

Generic drugs are the clinical equivalents of their brand name counterparts, containing the same active ingredients and working in the same way but there is a significant difference in cost.

Preferred brand name drugs (as well as ***Select Generics***) are therapeutically the same as ***non-Preferred brand name*** drugs (or Generic drugs), but are usually less expensive. The brand name drugs on the preferred list have been evaluated for safety by an independent review team of doctors and pharmacists and by the PBM. Brands that are more cost-effective are put on the preferred list. You can always check to see if a medication is on the Plan's preferred list but checking the website or calling the number listed in the ***Important Contact Information*** sheet or on your employee ID card.

There are significant differences between co-payments of generic and brand name drugs as well as a difference between the Select Generic and non-Select Generic drugs and the Preferred brand and non-Preferred brand name drugs. Select Generic drugs typically cost about half as much as Preferred brand name drugs. Non-Preferred brand name drugs have the highest co-payment and will cost you the most.

Non-Preferred Retail Pharmacy

If you have a prescription filled at a non-preferred retail pharmacy or you do not have your ID card with you when purchasing a prescription, you must pay the full cost of the prescription when you have it filled. You then need to submit your itemized receipt to the Fund Office. You will be reimbursed only the amount the Plan would pay for the drug at a preferred retail pharmacy, minus the applicable co-payment.

For a list of participating pharmacies, check the website or call the number shown on the ***Important Contact Information*** sheet provided by the Fund Office or on your employee ID card.

Mail Order Prescription Drug Benefits

If you or your eligible dependent(s) are being treated for a chronic condition (a long-term illness such as diabetes, hypertension, or a heart condition) and are required to take the same medication for 90 days or more, you must obtain your prescription through the mail order program.

You are responsible for a co-payment for each prescription. The amount of the co-payment is outlined in the applicable ***Schedule of Benefits***. Your co-payment depends on what medication you and your physician decide is best for your specific needs. Under this Plan, there are four tiers of co-payments: Select Generic, Generic, Preferred Brand, and Non-Preferred Brand.

To use the mail order service:

- Have your doctor write the prescription for a 90-day supply, with the appropriate refills.
- Mail your prescription, co-payment and the mail order form to the Mail Order Services of the PBM whose address is listed on the ***Important Contact Information***. Mail order forms may be obtained from the Prescription Benefit Manager (PBM). Allow up to 10 days to receive your order.

The Plan covers established federal legend drugs, a prescription legend drug is any medical substance required to bear the label "Caution: federal law prohibits dispensing without a prescription." This Plan also covers insulin (which is a non-legend drug), syringes and needles.

Prescription Drug Expenses Not Covered

The Prescription Drug Benefit program will not cover the following types of drugs (this list will be reviewed periodically to add new drugs):

- ✧ Non-prescription smoking deterrents.
- ✧ Over-the-counter vitamins.
- ✧ Drugs not requiring a prescription (including over the counter drugs), except for diabetic medications and supplies.
- ✧ Weight loss/appetite suppressants (such as Meridia), unless prescribed by a physician and approved by the Fund Case Manager.
- ✧ Hair loss treatments (such as Rogaine).
- ✧ Treatment for wrinkles (such as Retin A).
- ✧ Treatment for sexual dysfunction (such as Viagra), limited to eight pills/injection per month.

The Board of Trustees, in conjunction with the Fund's PBM, will review this list from time to time in light of new drugs approved by the FDA and other considerations, and revise the list of covered and non-covered drugs based on criteria established by Fund's PBM. Please contact the PBM for the most up-to-date information on which drugs are not covered by the Plan as well as which drugs are part of the formulary.

MEDICARE PRESCRIPTION DRUG COVERAGE

If you are entitled to Medicare Part A or enrolled in Medicare Part B, you can enroll in Medicare Prescription Drug Coverage (Medicare Part D). However, the Plan's prescription drug coverage is "creditable," which means the benefits are, on average, as good as or better than the standard Medicare coverage. Therefore, you do not have to enroll in Medicare Part D.

If you are an active employee and enroll in a Part D plan, your prescription drug benefits will remain the same and this Plan will coordinate with Medicare. If you are a retiree and you enroll

in a Medicare Part D Prescription Drug Plan, you will not be eligible to receive prescription drug benefits under the Plan and you will not be able to re-enroll in the Plan for prescription drug coverage in the future. However, you can continue to receive medical benefits as long as you remain eligible for Plan coverage.

For More Information About Medicare Prescription Drug Coverage

If you are eligible for Medicare, you will receive a Medicare & You handbook in the mail from Medicare. More detailed information about Medicare Prescription Drug Coverage will be included in this handbook.

To get more information:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (the telephone number will be included in the *Medicare & You* handbook).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited resources, you may be able to receive extra help to pay for Medicare Prescription Drug Coverage. To get more information about this extra help:

- Visit www.socialsecurity.gov.
- Call 1-800-772-1213 (TTY users should call 1-800-325-0778).

MEDICAL PLAN EXCLUSIONS

The following is a list of services, supplies and/or expenses that are **not covered (excluded) by the Medical Plan**. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the medical program has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan, and to determine eligibility and entitlement to Plan benefits. If you have questions about any procedures or services recommended by your doctor that are listed below, you should contact the Fund Office to see if they will be covered by the Plan. All benefits except Life Insurance and Accidental Death and Dismemberment Benefits are subject to the following exclusions.

EXCLUSIONS FOR CHARGES DUE TO PAYMENT LIABILITY BY ANOTHER PARTY

A. Due to bodily injury arising out of, or in the course of, any employment for wage or profit, or to disease covered by a Worker's Compensation Act or similar legislation.
B. Services that are eligible for payment under any other insurance (i.e. Medicare, automobile insurance, homeowners insurance or worker's compensation, etc.).
C. Services you would not have a legal obligation to pay in the absence of this or any other insurance coverage.
D. Services or supplies that are received from a dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee or any similar person or group.
E. Services to anyone who is on active military duty or related to past service in the armed forces of any government.
F. Charges for services or supplies that any school system is required to provide under any law.
G. Any claims incurred while in the custody of the state or local justice system.
H. Hospitalization furnished under federal, state, or other laws (except Medicaid), or military service related care in a veterans' facility or a hospital operated by the United States.

GENERAL EXCLUSIONS

A. Services or supplies not recommended or approved by a physician or surgeon licensed to practice medicine.

B. Services or supplies that are not considered Medically Necessary for your diagnosis and treatment.

C. The non-availability of other facilities will not be considered a valid reason for admitting a covered person to a higher level of care than is medically required for their condition.

D. Consultations required by hospital regulations that are not Medically Necessary for the disease entity or for “stand-by” services provided by hospital personnel.

E. Services made necessary by a disease contracted or injuries sustained after your effective date of coverage as a result of war, declared or undeclared, or any act of war.

F. Surgery to correct near-sightedness (radial keratotomy).

G. Routine or periodic physical examinations, testing and immunizations, which by law are required for employment, including immunizations, required for traveling outside of the United States.

H. Charges for counseling or psychotherapy in connection with developmental delay or learning disabilities.

I. Charges for telephone consultations, missed appointments or fees sometimes added for filling out a claim form or for visits outside of regularly scheduled office hours.

J. Durable medical equipment and personal convenience items which are primarily for comfort and convenience rather than a medical purpose, including but not limited to: air conditioners, humidifiers, purifiers, physical fitness equipment, heating pads, Jacuzzis, whirlpools, tanning beds and similar supplies which are useful to a person in the absence of illness or injury.

K. Surgery and any related services or supplies intended solely to improve appearance, unless it is:

   - Reconstructive surgery necessary due to disease or injury; or
   - To repair a congenital abnormality that causes a functional defect in your child.

L. Repair of complications resulting from plastic or cosmetic surgery or medications that were not Medically Necessary, unless the cosmetic surgery is covered and the treatment for the complication is Medically Necessary.

M. Treatment of sexual dysfunction except as otherwise covered under the Prescription Drug benefit.

N. Treatment leading to or in connection with transsexual surgery.

O. Any claims pertaining to surrogacy.

P. Reversal of sterilization procedures under any circumstance.

Q. Services and supplies for any condition related to the pregnancy of a dependent child.

R. Services or supplies in connection with any procedure or examination not incident to or necessary for diagnosis of any injury or sickness for which bonafide provisional diagnosis has been made because of existing symptoms.

S. Convalescent, custodial or sanatorium care or rest cures such as nursing home, home for the aged, sitters, homemaker's service, home health aide or care in a place that serves you primarily as a residence.

T. Exercise programs for treatment of any condition including membership fees for fitness centers (i.e. health spas, YMCA).

U. Personal services such as haircuts, shampoos and sets, guest meals and radio/telephone/television/ VCR/tape rentals.

V. Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission, or attempted commission by the Covered Individual, of an illegal act that the Plan Administrator determines in its sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual, unless such injury or illness is the result of domestic violence, or the commission or attempted commission of an assault or felony, or is the direct result of an underlying health factor. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.

W. Any charges for services that are mandated, such as but not limited to pre-marital blood test, marriage counseling, custody mediation, or alcohol/drug rehabilitation to avoid jail.

X. Services during a hospital stay or any period of a hospital stay which is primarily for diagnostic procedure or the patient's physical condition is such that hospitalization is not Medically Necessary.

Y. Hospital confinements for dentistry and dental surgery except:

   - ✧ For an individual with significant medical comorbidities requires intensive cardiac and/or respiratory monitoring during and immediately following the planned procedures and requires the presence of trained personnel in advanced cardiovascular life support; or
   - ✧ There is a documented presence of bleeding disorder such as hemophilia; or
   - ✧ The individual is severely developmentally disabled.

Z. Any services for substance use disorders including any and all inpatient admissions, outpatient services, and prescription drugs for alcohol and drug detoxification and rehabilitation (except for Class 5 employees as described in the Schedule of Medical benefits).

AA. Hospital admissions for physical therapy.

BB. Major Medical charges due to injuries sustained as the result of a motorcycle or Recreational vehicle accident, including physician visits, rehabilitation services, physical therapy, prescription drugs and durable medical equipment. Only the following benefits for such injuries are covered with the following limitations: inpatient hospital limited to $8,300 per confinement; physician hospital visits limited to $15 per day of confinement; outpatient surgery facility up to $3500 maximum per surgery; surgeon charges limited to $2,000 per surgery (no coverage for assistant surgeon; anesthesia limited to $800 per surgery).

CC. As determined by the Plan Administrator or its designee, expenses were incurred by any Covered Individual for injuries caused in a vehicular accident (vehicle referring to a foot or hand-powered device like a bicycle, a wagon/cart, a motor device, a watercraft or an aircraft vehicle) or motor vehicular accident if the Covered Individual was operating the vehicle while intoxicated (had a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred or no breathalyzer exam was performed or the person refused to submit to a requested breathalyzer or blood test) or was under the influence of illegal drugs; unless the injuries arise as a result of a physical or mental health condition. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal, or failure to prosecute) in connection with the vehicle or motor vehicle accident.

EXCLUSIONS FOR CERTAIN CHARGES

A. Procedures, treatments, drugs, services or supplies that are not approved or are considered experimental, investigational or ineffective procedures or treatments by the Food and Drug Administration or the American Medical Association.

B. Claims that are not submitted within one year (12 months) following the date of service.

C. Services rendered or supplies provided prior to the covered person's effective date, or after coverage is ended for any reason unless specifically provided for in this booklet.

D. Charges in excess of Plan limits.

E. Charges incurred during a covered person's temporary absence from the eligible provider's facility before discharge.

F. Services involving equipment or facilities used when the purchase, rental or construction has not been approved in compliance with applicable state laws or regulations.

G. Travel, whether or not recommended by a physician.

H. Chiropractic care, physical therapy, occupational therapy and acupuncture administered simultaneously.

I. Charges incurred when a patient is non-compliant with providers plan of care.

J. Services or supplies not listed as an eligible medical expense.

K. Services provided during any part of a stay at a hospital, detoxification facility or residential facility chiefly for bed rest, rest cure, convalescent, custodial or sanatorium care or diet therapy.

L. Long-term residential care.

M. Prescription drug co-payments.

N. Vitamins and other medications available over-the-counter.

O. Orthopedic shoes regardless of diagnosis.

P. Hypnotherapy, regardless of diagnosis.

Q. Routine adult care and physicals, except as specifically noted otherwise.

R. Any professional services such as those provided by a physician, an R.N., or any other individual or other medical professionals who are not employees of the hospital except when the charges are made by the hospital for such services by its employees.

S. Services of physicians or private duty or special nurses, or other private attendants or their board.

T. Charges for practitioners that are related to you by blood, marriage or adoption.

U. Technology, including treatments, procedures, drugs, biologicals or medical devices that are not Medically Necessary because they are:

- ✧ Experimental.
- ✧ Investigational.
- ✧ Obsolete.
- ✧ Ineffective.

EXCLUSIONS SPECIFIC TO OUTPATIENT HOSPITAL EXPENSES

A. Any services or supplies that are rendered or provided other than in a hospital outpatient or emergency department, an outpatient surgical center, or an emergency medical center.

B. A physician's office visit made on the same day as a surgery.

C. X-ray or laboratory work done for "checkup" purposes not incident and necessary to diagnosis of sickness or accidental bodily injury.

D. When an eligible employee receives covered outpatient treatment and then is admitted to a hospital as an inpatient, outpatient benefits will not be payable. In this case, the expense incurred as an outpatient will be considered part of the inpatient care and the expenses will be considered for payment under inpatient hospital expenses.

GENERAL EXCLUSIONS (APPLICABLE TO ALL MEDICAL SERVICES AND SUPPLIES)

A. **Costs of Reports, Bills, etc.:** Expenses for preparing forms and medical reports/medical records, bills, disability/sick leave/claim forms and the like; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, e-mailing charges, prescription refill charges, handicapped plates/automotive forms/interest charges, late fees, mileage costs, provider administration fees, concierge/retainer agreement/membership fees and/or photocopying fees.

B. **Educational Services:** Even if they are required because of an injury, illness or disability of a Covered Individual, the following expenses are not payable by the Plan for certain educational services, supplies or equipment, including, but not limited to:

- ✧ Computers.
- ✧ Computer devices/software.
- ✧ Printers.
- ✧ Books.
- ✧ Tutoring or interpreters.
- ✧ Visual aids.
- ✧ Vision therapy.
- ✧ Auditory or speech aids/synthesizers.
- ✧ Auxiliary aids such as communication boards.
- ✧ Listening systems.

- ✧ Device/programs/services for behavioral training, including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills.
- ✧ Programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc.
- ✧ Special education and associated costs in conjunction with sign language education for a patient or family members.
- ✧ Implantable medical identification/tracking devices.
- ✧ Residential schools, halfway house and group homes.

C. Expenses for **court-ordered services**, **parental custody services or adoption services**. This exclusion does not apply to mental health and/or substance abuse treatment that is both Medically Necessary and would otherwise be a covered benefit of the Plan.

D. Expenses for **biofeedback** (a technique to teach a person to use signals from their body to reduce tension/anxiety).

E. Expenses for **hypnosis/hypnotherapy** (following a hypnotic induction technique performed by the provider, hypnosis produces a wakeful state of focused attention and heightened suggestibility with diminished peripheral awareness).

F. Expenses for services related to **reading and learning disorders, dyslexia, educational delays, or vocational disabilities**.

G. Expenses for **Applied Behavioral Analysis (ABA) Therapy** (as defined in the Definitions section of this document) and related services.

H. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, generators, etc.

I. **Medical Students, Interns or Residents:** Expenses for the services of a medical student, intern or resident.

J. **Internet/Virtual Office/Telemedicine Services:** Expenses related to an online internet consultation with a physician or other health care practitioner, also called a virtual office visit/consultation, web visit, physician-patient web service or physician-patient e-mail service, or telemedicine (real time or store and forward types) tele-health, e-health, remote

diagnosis and treatment, real-time video-conferencing including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet provider.

EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES

A. **Allergy/Alternative/Complementary Health Care Services Exclusions**

- ✧ Expenses for acupuncture and/or acupressure rendered by a person other than as defined in the Glossary section of this SPD.
- ✧ Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.
- ✧ Expenses for prayer, religious healing, or spiritual healing, including services provided by a Christian Science Practitioner.
- ✧ Expenses for naturopathic, naprapathic and/or homeopathic services or treatments/supplies.
- ✧ Expenses for Experimental/Investigational allergy treatments including, but not limited to, sublingual (under the tongue) drops/oral antigen, rhino phototherapy, repository emulsion therapy (a form of therapy where certain materials are placed inside the body to improve allergies).

B. **Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions**

- ✧ Expenses for any items that are **not** corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment, including but not limited to air purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, water beds, and air conditioners.
- ✧ Expenses for replacement of lost, missing, or stolen, duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment.
- ✧ Expenses for corrective appliances and durable medical equipment to the extent they exceed the cost of standard models of such appliances or equipment.

C. **Durable Medical Equipment Exclusions**

See the exclusions related to corrective appliances and durable medical equipment.

D. **Hair Exclusions**

Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including:

- ✧ Prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or
- ✧ Expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees and/or hairpieces or hair analysis, except that the Plan will provide benefits for a hair prosthesis if it is required to replace hair lost as a result of treatment of disease by radiation or chemicals, alopecia universalis, totalis or alopecia areata.

E. **Home Health Care Exclusions**

- ✧ Expenses for any Home Health Care services other than part-time, intermittent **skilled nursing** services and supplies, except when the services of Home Health aides are payable under Hospice Services, as shown in the ***Schedule of Benefits*** for your Class.
- ✧ Expenses under a Home Health Care program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a physician.
- ✧ Expenses for a homemaker, custodial care, child care, adult care or personal care attendant, except as provided under the Plan's Hospice coverage.

F. **Maternity/Family Planning/Contraceptive Exclusions**

- ✧ Home Delivery: Expenses for pre-planned home delivery.
- ✧ Expenses for childbirth education, Lamaze classes, breast-feeding classes.
- ✧ Expenses related to the maternity care and delivery expenses associated with a pregnant dependent child or surrogate mother's pregnancy.
- ✧ Expenses related to cryostorage of umbilical cord blood or other tissue or organs.
- ✧ Reversal of sterilization.

G. **Nondurable Supplies**

See the exclusions related to corrective appliances.

H. **Nursing Care Exclusions**

Expenses for services of private duty nurses/health care personnel.

I. **Rehabilitation Therapy Exclusions (Inpatient or Outpatient)**

- ✧ Expenses for educational, job training, vocational rehabilitation.

- ✧ Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or, in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to cognitive rehabilitation, coma stimulation programs and like services.
- ✧ Expenses for maintenance rehabilitation.

J. **Sleep Disorders/Snoring/Obstructive Sleep Apnea**

Expenses related to the medical or surgical treatment of sleep disorders or snoring including medical equipment, with the exception of diagnostic sleep studies and for treatment of documented obstructive sleep apnea.

K. **Smoking Cessation or Tobacco Withdrawal Exclusions**

Expenses for tobacco/smoking cessation products such as nicotine gum or patches, or other services or programs except as may be payable under the Prescription Drug Benefit.

L. **Vision Care Exclusions**

- ✧ Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK), Automated Keratoplasty (ALK), Laser In-Situ Keratomileusis (LASIK) or implantable contact lenses (ICL).
- ✧ Orthokeratology lenses for reshaping the cornea of the eye to improve vision. The Plan will allow the stated benefits available for contact lenses (refer to the Vision Benefits section on page 74) to be extended toward the payment of FDA-approved orthokeratology lenses.

M. **Weight Management and Physical Fitness Exclusions**

- ✧ Expenses for medical or surgical treatment of obesity (bariatric surgery), including, but not limited to, drug therapy, gastric restrictive procedures, gastric or intestinal bypass, reversal of a previously performed weight management surgery, weight loss programs, dietary instructions, skin reduction procedures/treatment and any complications thereof, even if those procedures are performed to treat a comorbid or underlying health condition <u>except</u> bariatric surgery as provided by the Plan regarding morbid obesity (a weight of at least 40 pounds more than normal body weight for the patient's age, sex, height and body frame based on Body Mass Index BMI weight tables generally used by physicians to determine normal body weight).

- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, work hardening and/or weight training services.
- Expenses for medical or surgical treatment of severe underweight, including, but not limited to: high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with Medically Necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by physicians to determine normal body weight.

HEARING AID BENEFITS—(ALL CLASSES)

A Hearing Aid benefit is offered to all Plan employees and eligible dependents in all Classes.

HOW THE PLAN WORKS

The Plan pays up to a maximum of $1,500 toward the cost of each hearing aid (right and left) every three years.

EXPENSES COVERED

You are entitled to the following hearing aid benefits:

- ✧ Hearing test, analysis or evaluation performed by a physician, otologist or audiologist.
- ✧ Purchase and installation of a hearing aid provided subsequent to the date of a written recommendation by a physician or otologist.

EXPENSES NOT COVERED

Coverage for the following services is excluded:

- ✧ Expenses not recommended or approved by a physician or otologist.
- ✧ Expenses for which benefits are payable under Workers' Compensation.
- ✧ Benefits payable under Medicare or any other governmental plan.
- ✧ Special procedures or training, such as lip reading courses, schooling or institutional expenses.
- ✧ Charges for services or supplies that are covered in whole or in part under any other portion of the Plan.
- ✧ Batteries or repairs of hearing aids.
- ✧ Dispensing fees.

VISION BENEFITS—(ALL CLASSES)

Vision benefits are offered to all employees and eligible dependents in all Classes.

Vision benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. Employees may decline vision benefits (refer to "Declining Vision and/or Dental Benefits" on page 13 for more information).

HOW THE PLAN WORKS

You can receive your vision services at any provider you choose, but you will have to pay the difference, if any, between the Plan maximum and what your provider charges.

Contact the Fund Office to get a list of participating vision care providers and the necessary claim form.

Benefits for each individual are paid once every two years. The maximum vision benefit is $150 per person per year, except pediatric exams for children up to age 19 are reimbursed according to the Fund's fee schedule. Benefits are as follows:

SCHEDULE OF BENEFITS

Service	Annual Maximum
Eye Examination (by an optometrist or ophthalmologist)	$50
Eyeglass Lenses, Frames or Corrective Contact Lenses * Includes contact lens fitting	$100
Vision Therapy (employees and their eligible dependents)	3 visits per adult per lifetime and 12 visits per child per lifetime Precertification required

EXPENSES COVERED

The following vision benefits are covered up to the Plan specified maximums above:

- ✧ Services provided by a licensed optician, optometrist or ophthalmologist.
- ✧ Eye examination by a licensed optometrist or ophthalmologist.
- ✧ Prescription lenses, including prescription sunglass lenses.
- ✧ Frames.
- ✧ Vision therapy.

EXPENSES NOT COVERED

The following services are not covered under the Plan:

- ✧ Any service not provided by a licensed optician, optometrist or ophthalmologist.
- ✧ Eyeglasses or contact lenses not requiring a prescription.
- ✧ Eyeglasses or contact lenses used for cosmetic purposes.
- ✧ Contact lens fitting.

DENTAL BENEFITS—CLASS 5 ONLY

The Plan offers comprehensive dental coverage for ONLY Class 5 employees and their eligible dependents.

Dental benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. Employees may decline dental benefits (refer to the “Enrolling for Coverage” section for more information).

HOW THE PLAN WORKS

The Fund has contracted with a Dental Preferred Provider Organization (PPO). The maximum annual family benefit is $2,750; except preventive treatments (prophylaxis and fluoride treatment) for children up to age 19 are not subject to the annual family maximum, even after the annual family maximum is reached. All claims paid on behalf of your family during a calendar year will count toward the annual maximum.

The dental PPO is comprised of a panel of network dental providers who have agreed to accept the Fund’s fee schedule as payment in full*, up to Plan limits. You can receive dental services from any dental provider you choose. However, when you receive dental care from a non-network dentist, you will have to pay the difference, if any, between the provider’s charge and the Fund’s fee schedule allowance for services provided.

To obtain a list of PPO participating dentists, contact the Fund Office. You can also check the dental provider’s website.

*Some dental PPO network providers require a co-payment for certain services. To verify if a provider can charge you a co-payment for a particular service, contact the Fund Office.

EXPENSES COVERED

The following dental services are covered up to the Fund's fee schedule, with annual family expenses not to exceed the $2,750 maximum:

- Diagnostic examinations.
- Oral prophylaxis once every six months.
- X-rays (panoramic or full mouth once every three years).
- Topical fluoride for children up to age 19, once every six months.
- Sealants for children up to age 15.
- Fillings.
- Extractions.
- Oral surgery.
- Anesthesia for dental treatment.
- Extraction of fully boney impacted teeth are payable under the Medical Plan.
- Palliative services (to relieve pain).
- Root canal treatment.
- Night guards for bruxism, up to $150.
- Inlays.
- Onlays.
- Treatment for Temporomandibular Joint (TMJ) up to the TMJ maximum of $1,000 per person per lifetime (payable under the Medical Plan).
- Dentures (limited to one set every five years from date of insertion).
- Bridge work and crowns. Bridge work is eligible for replacement after five years from date placed, or sooner if the Fund determines that the original work was inferior, and was reviewed by the Fund's consulting dentist, and the charge does not exceed your annual family dental maximum.
- Dental implants, including abutment and crown, up to $1,320 (implant $550, abutment $330, crown $440).
- Periodontal treatment (covered at 50% of Fund's fee schedule, up to annual dental maximum).
- Accident related dental expenses (injuries to sound, natural teeth) will be covered under the medical plan. (Applies only to sound, natural teeth, free of active chronic decay, that have at least 50% bony support, are functional in the arch, have not been excessively weakened by prior dental procedures, and are not artificial teeth, crowns, bridges, dentures or pontics.)

Orthodontia Treatment

Orthodontia is covered at 50% of reasonable and customary charges, up to a maximum lifetime benefit of $2,000 per person. The orthodontia benefit is payable in addition to the annual family dental benefit of $2,750. The Plan pays its portion in eight equal quarterly payments after the appliances are placed.

EXPENSES NOT COVERED

Expenses for the following services are not covered under the dental plan:

- Expenses for services and supplies for dental work done for primarily cosmetic purposes or due to occupationally related conditions.
- Expenses for services and supplies:
  - Received in a U.S. Government hospital.
  - Furnished elsewhere by or for the U.S. Government.
  - Provided by any governmental plan or law under which you or your dependent are or could be covered.
- Expenses for the replacement of lost, missing or stolen orthodontic appliances (such as retainers).

YOUR LIFE INSURANCE AND AD&D BENEFITS—(ALL CLASSES)

DESIGNATING YOUR BENEFICIARY

Be sure to name your beneficiary. Contact the Fund Office for the beneficiary forms. Then complete and return them so that the person(s) you want to receive benefits gets them, in the event of your death.

When you become eligible for life insurance and/or AD&D benefits, you'll be asked to name a person or persons who will receive the benefit if you should die. Your beneficiary may be any person or persons you name at the time of enrollment. You may change your beneficiary at any time by writing, calling or visiting the Fund Office to request the appropriate forms. The last written beneficiary designation, which has been properly completed and signed by you and received by the Fund Office, will determine who is eligible to receive a life insurance benefit after your death.

If you name more than one beneficiary, you should indicate how your benefits should be divided. The initial designation or change of designation will take effect on the date you provide the beneficiary designation form to the Fund Office.

It's important that you name a beneficiary. If you do not name a beneficiary, or if your beneficiary is not living at the time of your death, your benefit will be paid to your survivors as follows:

- Spouse or spousal equivalent, or if none;
- Children, in equal shares, or if none;
- Parent(s), in equal shares, or if none;
- Brothers and sisters, in equal shares, or if none;
- Your estate.

LIFE INSURANCE BENEFITS

A life insurance benefit will be paid to your beneficiary in the event of your death from ***any cause*** at any time, provided you are eligible for coverage at the time of your death.

Life Insurance Benefit Amounts

Your beneficiary will receive the life insurance benefit, in addition to any other benefits he or she may be entitled to receive, according to the following schedule(s):

Welfare Fund Participants with Less than 10 Pension Credits*

Eligibility Class	Amount
Class 1	$4,000
Class 2	$8,000
Class 3	$12,000
Class 4	$16,000
Class 5	$20,000

Welfare Fund Participants with 10 or More Years of Pension Credits*

Pension Years	Amount
10 – 14.9	$20,000
15 – 19.9	$25,000
20 – 24.9	$30,000
25 – 29.9	$35,000
30 or more	$40,000

*Your life insurance benefit reduces by 50% when you turn age 70.

Class 5 Pensioner Death Benefit

The amount of life insurance in effect at the time of retirement for Class 5 Participants will be continued for one year from the date of retirement. Then, the life insurance benefit will be reduced as shown in the following chart:

Year of Retirement	Amount
After retirement through 1st year	$20,000
2nd year	$16,000
3rd year	$12,000
4th year	$9,000
5th year	$7,500
6th and all subsequent years of retirement	$5,000

If the amount in effect at the date of retirement was less than $5,000, life insurance coverage will be continued at the lesser amount.

Converting Your Life Insurance (Active Employees)

When your Fund coverage terminates, you may change the group life insurance policy provided by the Fund to an individual life insurance policy, without having a medical examination, during the 31-day period after life insurance benefits under the Fund terminate.

> You don't need a medical examination to convert your life insurance policy within 31 days of losing coverage.

Your individual life insurance benefits will be paid in the event your death occurs during the 31 days after coverage terminates. You are responsible for paying the premiums for this conversion. The individual policy premium will be the same payment as it ordinarily would be if you applied for an individual policy at that time.

If you become Totally Disabled before you reach age 60, life insurance will continue at no cost to you as long as you remain Totally Disabled.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

An Accidental Death and Dismemberment (AD&D) benefit will be paid if any of the following losses occur through accidental means, on or off the job. The loss must occur within 90 days after the accident and while you are an eligible Participant. Payment will be made in addition to any other benefits you may receive.

AD&D Benefit Amounts

Welfare Fund Participants with Less than 10 Pension Credits

	Benefit Payable				
Type of Loss	**Class 1**	**Class 2**	**Class 3**	**Class 4**	**Class 5**
Loss of Life (payable to your beneficiary)	$4,000	$8,000	$12,000	$16,000	$20,000
Loss of (payable to you): ✧ Both feet ✧ Both hands ✧ Sight in both eyes ✧ One hand and one foot ✧ Any combination of hand, foot, or sight of one eye ✧ Loss of speech and loss of hearing ✧ Paralysis of both arms and both legs ✧ Permanent and irreversible damage to the brain	$4,000	$8,000	$12,000	$16,000	$20,000
Loss of (payable to you): ✧ Arm permanently severed at or above the elbow ✧ Leg permanently severed at or above the knee	$3,000	$6,000	$9,000	$12,000	$15,000
Loss of (payable to you): ✧ One hand ✧ One foot ✧ Sight in one eye ✧ Loss of speech or hearing ✧ Paralysis of both legs ✧ Paralysis of the arm and leg on either side of body	$2,000	$4,000	$6,000	$8,000	$10,000

Loss of (payable to you): ✧ Thumb and index finger of same hand ✧ Paralysis of one arm or leg	$1,000	$2,000	$3,000	$4,000	$5,000
Coma	One percent of the full amount of the benefit payable monthly beginning on the 7th day of the coma for the duration of the coma to a maximum of 60 months				
	$40 per month	$80 per month	$120 per month	$160 per month	$200 per month

Welfare Fund Participants with 10 or More Years of Pension Credits

	Benefit Payable				
Type of Loss	**10 – 14.9 Pension Credits**	**15 – 19.9 Pension Credit**	**20 – 24.9 Pension Credits**	**25 – 29.9 Pension Credits**	**30 or more Pension Credits**
Loss of Life (payable to your beneficiary)	$20,000	$25,000	$30,000	$35,000	$40,000
Loss of (payable to you): ✧ Both feet ✧ Both hands ✧ Sight in both eyes ✧ One hand and one foot ✧ Any combination of hand, foot, or sight of one eye ✧ Loss of speech and loss of hearing ✧ Paralysis of both arms and both legs ✧ Permanent and irreversible damage to the brain	$20,000	$25,000	$30,000	$35,000	$40,000
Loss of (payable to you): ✧ Arm permanently severed at or above the elbow ✧ Leg permanently severed at or above the knee	$15,000	$18,750	$22,500	$26,250	$30,000
Loss of (payable to you): ✧ One hand ✧ One foot ✧ Sight in one eye ✧ Loss of speech or hearing ✧ Paralysis of both legs ✧ Paralysis of the arm and leg on either side of body	$10,000	$12,500	$15,000	$17,500	$20,000

<table>
<tr><td>Loss of (payable to you):
✧ Thumb and index finger of same hand
✧ Paralysis of one arm or leg</td><td>$5,000</td><td>$6,250</td><td>$7,500</td><td>$8,750</td><td>$10,000</td></tr>
<tr><td rowspan="2">Coma</td><td colspan="5">One percent of the full amount of the benefit payable monthly beginning on the 7th day of the coma for the duration of the coma to a maximum of 60 months</td></tr>
<tr><td>$200 per month</td><td>$250 per month</td><td>$300 per month</td><td>$350 per month</td><td>$400 per month</td></tr>
</table>

Please note that “loss” is defined in the Certificate of Insurance issued by the insurance carrier. Payment for all losses by any one accident may not be more than the full amount of insurance, but the benefits paid on account of one loss will not prevent further payment for losses resulting from subsequent accidents.

These benefits will not be paid for death or any other loss that occurs more than 90 days after the accident, or for any loss caused by:

- ✧ War, insurrection, or participation in a riot.
- ✧ Suicide.
- ✧ Disease, bodily or mental infirmity.
- ✧ Infection other than a septic infection of or through a visible accidental wound.
- ✧ Operating or riding in any aircraft, except as a passenger on a regularly scheduled commercial flight.

ADDITIONAL OCCUPATIONAL COVERAGE - ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Additional occupational coverage, Accidental Death and Dismemberment (AD&D) benefits will be paid if any of the following losses occur through accidental means while on the job. To be eligible for this benefit, you must be an active Employee in any Class and working in Covered Employment. You must be working on-site for the benefit to be payable. The loss must occur within 395 days of the accident and while you are eligible. Payment will be made in addition to any other benefits you may receive.

Type of Loss	Benefit Amount
Loss of Life (payable to your beneficiary)	$100,000
Loss of (payable to you): ✧ Two or more of the following: hand, foot, sight, speech or hearing ✧ Paralysis of both upper and lower limbs	$100,000
Loss of (payable to you): ✧ One hand or foot ✧ Sight ✧ Speech ✧ Hearing ✧ Total paralysis of upper and lower limbs on one side of the body	$50,000
Loss of (payable to you): ✧ Total paralysis of both lower limbs or both upper limbs on one side of the body	$75,000
Loss of (payable to you): ✧ Thumb and index finger of the same hand ✧ Four fingers of same hand ✧ Total paralysis of one upper or one lower limb	$25,000
Coma (if person becomes comatose within 31 days of the covered accident and remains in a coma for at least 31 days)	One percent of principle sum ($1,000) per month up to 11 months, then 100% in a lump sum

These benefits will not be paid for death or any other loss that occurs more than 365 days after the accident, or for any loss or injury that is caused by or results from:

- ✧ Intentionally self-inflicted injury.
- ✧ Suicide or attempted suicide.

- As a result of war or an act of war, if the loss occurs while serving in the military, naval or air forces of any country, combination of countries or international organization; and as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the loss occurs while serving in such forces and are outside the home area.
- As a result of war or an act of war, if the loss occurs while serving in any civilian non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization; and as a result of the special hazards incident to service in any civilian non-combatant unit supporting or accompanying such forces, provided the loss occurs while serving in such unit and are outside the home area.
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.
- Loss to which a contributing cause was the Covered Individual's commission of or attempt to commit a felony, or to which a contributing cause was their being engaged in an illegal occupation.

All provisions of the life insurance and/or AD&D benefits are subject to contract and described in the Certificate of Group Insurance issued by the applicable insurance company. If there are any discrepancies between this booklet and the certificate or contract, the certificate or contract will govern. The Certificate of Insurance defines loss and injury as well as describes additional provisions that may be abdicable including claims and appeals procedures.

HOW TO CLAIM BENEFITS

HOW TO FILE A CLAIM

This section contains information about filing claims and what you should do if your claim is denied.

Important! A claim will be suspended due to missing participant enrollment information. In addition, the filing of any fraudulent or false claims will cause loss of coverage and could lead to criminal charges.

All claims must be submitted within one year from the date of service. All claims filed after this time will not be considered for payment. Late charges (i.e. additional hospital late charges) **must** be submitted within 120 days from original payment by the Fund; failure to do so will result in denial of payment.

Please make any needed copies for your own records before you submit the original statements to the Fund Office. All materials submitted will be retained by the Fund Office for our files.

Claim Submissions	
Type of Claim	**Where to Submit Claims**
In-network medical providers/facilities	***No claim forms are needed***. Present your identification card to the provider. The card will instruct the provider how to submit claims directly. Do not pay a participating provider at the time of service other than the applicable co-payment. Payment will be paid directly to the provider for eligible services.
Out-of-network medical providers	Out-of-network providers have the option to request that you pay at the time of service or to bill the Fund directly. ***If the provider requires you to pay for services up-front,*** request an itemized bill* or completed claim form (often referred to as the CMS (HCFA) 1500 (for providers) or the UB-92 (for facilities) from the provider and forward it to the Fund Office. The Fund will reimburse you in accordance with out-of-network guidelines for eligible expenses. Applicable deductibles and coinsurance will be deducted from charges. ****Itemized bills must include the following information:*** ✧ Provider's name, address, credentials and Tax ID number ✧ Patient name ✧ Patient date of birth ✧ Date(s) of service ✧ CPT procedure code(s) ✧ Itemized cost of each service ✧ Diagnosis ✧ Employee identification number ***If the provider agrees to bill the Fund directly,*** give the provider your identification card for instructions on how to file a claim. The provider can bill you the difference between the amount charged and the reimbursement made by the Fund. To determine how much you owe the provider, please refer to the Explanation of Benefits you receive from the Fund for services provided.

<table>
<tr><th colspan="2">Claim Submissions</th></tr>
<tr><th>Type of Claim</th><th>Where to Submit Claims</th></tr>
<tr><td>Prescription Drugs</td><td>You do not need claim forms when visiting an in-network network retail pharmacy. Simply present your ID card and your prescription to the pharmacist. When you present a prescription to a pharmacy to be filled under the terms of this Plan, that request is not considered a claim under these procedures.

For mail order claims, or if you use a non-participating pharmacy, you need to file a claim form. Contact the Fund Office for a claim form. Claims must be filed within one year of the fill date.</td></tr>
<tr><td>Vision</td><td>Send all claims to the Fund Office.</td></tr>
<tr><td>Dental</td><td>Send all claims to the Fund Office.</td></tr>
<tr><td>Life and AD&D Insurance</td><td>In the event of your death, your beneficiary should call the Fund Office for help in filing a claim. If you have an injury covered under the AD&D Insurance Benefit program, you should file a claim. Any applicable benefits will be paid to you.</td></tr>
<tr><td>When you or your dependents have secondary coverage

When another carrier is Primary

Please be aware that when another carrier is primary, you must follow the guidelines of the primary plan. The Fund does not pay for charges denied by the primary plan due to failure to follow the primary plan's guidelines</td><td>When you, your spouse/spousal equivalent or other covered dependents have other primary group health coverage, all claims must be submitted to the primary carrier first. Follow these steps:
✧ Present the primary insurance identification card as your primary carrier, and your insurance card provided by the Fund as your secondary carrier.
✧ The instructions provided on your insurance card(s) will direct the provider where to submit claims.
✧ After the primary carrier has processed the claim, the Fund will then process your claim for secondary benefits. You will then receive an Explanation of Benefits from the Fund showing the amount you owe, if any, to the provider.
✧ In the event that the provider will not bill a secondary insurance and or requires you to pay up-front, please obtain an itemized bill* from the provider and attach the corresponding primary Explanation of Benefits and submit to the Fund for processing.</td></tr>
</table>

Claim Submissions	
Type of Claim	**Where to Submit Claims**
When Medicare is primary	All claims must be submitted to Medicare first. Follow these steps: ✧ Present your Medicare identification card as your primary carrier, and your insurance card provided by the Fund as your secondary carrier. ✧ The instructions provided on your insurance card(s) will direct the provider where to submit claims. ✧ After Medicare has processed the claim, the Fund will then process your claim for secondary benefits. You will then receive an Explanation of Benefits from the Fund showing the amount you owe, if any, to the provider. ✧ In the event that the provider will not bill a secondary insurance, does not accept Medicare assignment and/or requires you to pay up-front, please obtain an itemized bill from the provider, attach the corresponding primary Explanation of Benefits, and submit them to the Fund Office for processing.

TYPES OF HEALTH CARE CLAIMS

There are five basic types of health care claims:

Types of Health Care Claims	
Urgent Care	An urgent care claim is a claim for medical care or treatment that: ✧ Would seriously jeopardize your life or health; or ✧ Would subject you to severe pain that cannot be adequately managed without care or treatment, in the opinion of a doctor with knowledge of your condition.
Pre-service	A pre-service claim is a request for benefits under this group health Plan where the Plan preconditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care.
Post-service	A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services.

Concurrent Care	A concurrent care claim is any request to extend the duration or number of treatments previously approved through a pre-service claim (such as precertification of the number of days of a hospital stay). A concurrent claim also refers to a Plan decision to reduce or terminate a pre-approved course of treatment before the end of the approved treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.
Life Insurance/Accidental Death and Dismemberment (AD&D) Claim	A life insurance/AD&D claim is a claim for benefits under the Plan to which the Plan conditions availability of the benefit on proof of a claimant's death or proof of accidental dismemberment.

HEALTH CARE CLAIMS DECISIONS AND BENEFIT PAYMENTS

When you submit a claim for benefits to the Fund Office, the Fund Office will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. In some situations, the Fund has the right to request a physical exam by a doctor of its choice (at the Fund's expense).

> **Important.**
>
> The Fund Office must be notified of the following events:
>
> - ✧ Motor vehicle accident;
> - ✧ Motorcycle/recreational vehicle accident;
> - ✧ Lawsuits in process involving injury or illness;
> - ✧ Injury on the job;
> - ✧ Injury on property other than your own;
> - ✧ Injury resulting from product failure; and
> - ✧ Participation in any research program or other arrangement, which may require medical or psychiatric monitoring, treatment or procedures of any kind.

Generally, all health care benefits will be paid as soon as administratively possible. The Plan or its designated Utilization Review provider will notify you of its initial decision within certain time frames (described below). If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, the Plan will give you written notice of its decision about your claim.

The deadlines differ for the different types of claims as shown in the following information:

- ✧ ***Urgent Care***. Urgent care claims may be made orally or in writing to the Plan. In the case of an urgent care claim, if a health care professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), the health care professional will be considered by this Plan to be the authorized representative bypassing the need for completion of the Plan's written authorized representative form. An initial determination will be made within 72 hours from receipt of your claim. If, during the review, additional information is needed from you to process your claim, you will be notified within 24 hours. You will then have 48 hours to respond. You may call the Fund Office to provide the information. You will be notified of the decision within 48 hours of when the additional information is submitted. Due to the nature of an urgent care claim, you may be notified of a decision by telephone no later than three calendar days after the oral notice. This will be followed by a written notice of the same information.
- ✧ ***Pre-service***. Pre-service claims may be submitted orally or in writing to the Plan. An initial determination will be made within 15 days from receipt of your claim. If additional time is necessary, you will receive notice within that initial 15-day period explaining why there will be a delay in the decision. You will also be given a date, no later than 15 days after the initial 15-day period, when you will receive a decision. If, during the review,

additional information is needed to process your claim, you will be notified within the time period explained above. You will have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will make a determination. The ***Schedules of Benefits*** indicate the benefits that require precertification. You will be notified orally and in writing of the determination.

✧ ***Post-service***. Plan benefits for post-service claims are considered for payment upon receipt of a written (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim usually contains the necessary proof of claim, but sometimes additional information or records may be required. The Plan will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim.

Generally, Plan benefits for a hospital or health care facility will be paid directly to the facility. Plan benefits for surgery will usually be paid directly to the surgeon and anesthesiologist providing the services. This is because the Plan's financial responsibility for eligible benefits is generally automatically assigned to the provider of the service unless the claim is marked that the bills have been paid by the covered person. For eligible claims, the Plan pays its portion of the billed services and you, the covered person, are responsible to pay your portion of the claim to the provider. When health care services are provided through the Preferred Provider Organization (PPO), the PPO health care facility/provider will usually submit the written proof of claim directly to the PPO Network for repricing or to the Plan.

If you pay for non-PPO network health care services at the time services are provided, you may later submit the bill to the Fund Office. At the time you submit your claim, you must furnish evidence acceptable to the Fund Office that you or your covered dependent paid some or all of those charges. If non-PPO Plan benefits will be paid to you, they will be paid up to the amount allowed by the Plan for those expenses.

The Plan will inform you of its decision on a post-service claim within 30 days of when you file the claim. If there will be a delay in making a decision on your claim, within that 30-day period, you will receive a notice giving a date – no later than 15 days after the ending of the initial 30-day period — by which you can expect a decision. If, during the review, additional information is required, you will be notified within the required time period explained above. You will have 45 days to provide the additional information. The Plan will then make a claim determination no later than 15 calendar days from the earlier

of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received. If the post-service claim is approved, you will be notified in writing on a form commonly referred to as an Explanation of Benefits or EOB. The provider of service (or you when applicable) will be paid according to Plan benefits. If the post-service claim is denied in whole or in part, a notice of this initial denial will be provided to you in writing on the Explanation of Benefits or EOB form.

- ✧ **Concurrent Care.** If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated. Concurrent claims that are an urgent care claim will be processed according to the initial review and appeals procedures and timeframes noted under the Urgent care claim section of this section. Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Pre-service or Post-service claim sections of this section. If the concurrent care claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided no later than three calendar days after the oral notice. If the concurrent care claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.
- ✧ **Accidental Death and Dismemberment and Life Insurance Claims**: The insurance carrier will make a decision on the claim and notify you and/or your beneficiary of the decision within a reasonable period of time, but not later than 90 days after receipt of the claim. If the insurance carrier requires an extension of time, the insurance carrier will notify you before the expiration of the 90-day period of the reason for the delay and when the decision will be made. A decision will then be made within 90 days from the end of the initial 90-day period.

  The insurance carrier, at its own expense, has the right to have a doctor examine any insured individual when it deems it reasonably necessary while there is a claim pending under their policy. The insurance carrier also has the right to make an autopsy in case of death where the law does not forbid it.

  Generally, when in-network providers submit the claims, payment is made directly to the provider. In-network providers handle all the paperwork for you. However, if you submit

the claim, payments are generally made directly to you, unless you assign benefits to the Provider.

IF A CLAIM IS DENIED

If all or part of your claim is denied, the Plan will notify you in writing, providing:

- The specific reason or reasons for the decision;
- Reference to the Plan provisions on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;
- A copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a civil lawsuit under ERISA if you decide to appeal and the appeal is denied;
- A copy, or a statement that a copy is available to you at no cost upon request, of any internal rule, guideline, protocol or similar criteria that was relied on in making the decision;
- An explanation of the scientific or clinical judgment related to your condition, or a statement that a copy is available to you at no cost upon request, if your claim is denied due to medical necessity, Experimental treatment or similar exclusion or limit;
- A statement explaining that the Plan will identify any medical or vocational expert that the Plan received the advice of with respect to your claim upon your request; and
- A notice, including a description of the expedited review process, if your appeal is due to the denial of an urgent care claim.

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Fund Office. If a disagreement is not resolved, there is a formal procedure you can follow to have your claim reconsidered.

APPEALING A DENIED CLAIM

Health Care Benefits Appeal Procedures

The Fund and Board of Trustees, in making decisions on claims and appeals, will apply the terms of the Plan and any applicable guidelines, rules and schedules. Additionally, the Fund and the Board of Trustees will periodically verify that benefit determinations are made in accordance with such documents, and where appropriate, applied consistently with respect to similar claims. The Fund and Board of Trustees will take into account all information you submit in making decisions on claims and appeals.

You may name a representative to act on your behalf. You must notify the Fund Office in writing of your representative's name, address, and telephone number. For urgent care claims, a health care provider that has knowledge of your medical condition may act as your authorized representative.

If your claim is denied in whole or part, you (or your authorized representative) may, within 180 days after receiving the denial, appeal the denial by sending a written request for review to the Appeals Committee/Board of Trustees at the following address:

Heavy and General Laborers Welfare Fund
700 Raymond Boulevard
Newark, NJ 07105

You may appeal denials of urgent care claims either orally by calling the Fund Office or in writing to the Board of Trustees. All information necessary to decide the appeal may be transmitted via telephone, facsimile or other available method.

Your written appeal (or oral appeal for urgent care claim denial) should state the reason for your appeal. You (or your authorized representative) may receive, upon request and free of charge, reasonable access to and copies of any documents relevant to your claim and may submit issues and comments in writing. A document is considered relevant if it was relied on in making the decision, was submitted, considered or generated (regardless if relied on) or demonstrates compliance with claim processing requirements.

The Board of Trustees or its authorized committee (Appeal's Committee) will determine all requests for review for claims that were denied based on the Fund's eligibility rules. The review will take into account all comments, documents, records and other information submitted that relate to the claim, without regard to whether such information was submitted or considered in the initial benefit denial, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate.

You must file your appeal within 60 days after you receive notice in the case of a claim involving Life Insurance and Accidental Death and Dismemberment Insurance Claims. Failure to appeal will constitute a waiver of your claim to the benefit. Such claims should be filed with the Life Insurance carrier who is listed in the ***Important Contact Information*** sheet attached to this SPD.

Appeal Time Frames

If the Appeals Committee/Board of Trustees reviews your appeal, the amount of time they have to issue a decision after receiving your appeal will depend on the type of claim.

- ***Urgent Care***. Appeals of urgent care claims will be decided within 72 hours after the appeals Committee/Board of Trustees or its authorized committee receives the appeal.
- ***Pre-service***. Appeals of pre-service claims will be decided within 30 days after the Appeals Committee/Board of Trustees or its authorized committee receives the appeal.
- ***Post-service***. The Board of Trustees' Appeals Committee will review your claim and appeal and report its recommendation to the Board of Trustees no later than the date of the next regularly scheduled meeting of the Board of Trustees 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 determination on your appeal may be made by no later than the date of the second regularly scheduled 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 regularly scheduled meeting of the Board of 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 Administrator will notify the claimant in writing of the extension.

- ***Concurrent Care.*** Appeals of concurrent care claims are governed by the provisions above for urgent care, pre-service, or post-service claims, whichever applies to the particular claim.
- Accidental Death and Dismemberment and Life Insurance Claims: The Life Insurance Company will make a decision within a reasonable period of time, but not later than 60 days following receipt of your request for a review. If there are special circumstances that require an extension of time (up to 60 days), you will be notified in writing of the special circumstances and the date by which the insurer expects to render a decision on review.

Notice of Appeal Denial

If all or part of your claim is denied on appeal, you will receive a written explanation that describes:

- The specific reason for the denial;
- The specific provisions of the Plan document on which the decision was based;
- Any additional information necessary to reconsider your claim (and why that information is necessary);
- Notice that you may receive, upon request, access to and free copies of documents and records relevant to your claim; and
- A statement of your right to bring a lawsuit under ERISA.

If an internal rule, guideline or protocol was relied on in making the decision, you will receive either a copy of the rule, guideline or protocol, or a statement that it was relied upon and is available upon request and free of charge. If the decision on a medical claim is based on medical necessity, experimental treatment or a similar exclusion or limit, you will receive either an explanation of the scientific or clinical judgment related to your condition or a statement that such an explanation is available, free of charge, upon request.

If the initial decision on a medical claim was based in whole or in part on a medical judgment, the Appeals Committee/Board of Trustees will consult with a health care professional with training and experience in the relevant/applicable medical/dental field who was not consulted in the initial determination (but not a subordinate of such person). In reviewing a denied medical claim, the Board of Trustees will not automatically presume that the Fund's initial decision was correct. Rather, the medical claim will be reviewed independently based on all information you provided to the Board of Trustees, including any new information that you provide that was not reviewed during the Fund's initial decision.

Limitation on When a Lawsuit May Be Started

If the Board of Trustees denies your appeal, or fails to furnish you with a decision within the time period indicated above, you then have a right to bring a civil action under ERISA, provided such action must be commenced within one year from the date of the Trustees decision. If the Trustees fail to render a decision within the time period indicated above, such civil action must be commenced within one year of the end of that time period.

COORDINATION OF BENEFITS

This Plan has been designed to help you and your covered dependents meet the costs associated with an illness or injury. Since it is not intended that you or they receive greater benefits than the actual covered expenses incurred, any coverage you or they have under other "plans" will be taken into account in determining the amount of benefits payable under this Plan; that is, the benefits under this Plan will be coordinated with the benefits of the other plan.

Each year, you will receive paperwork from the Fund inquiring into whether your spouse/spousal equivalent or other eligible dependents are entitled to benefits under another health plan. This information is required to determine the proper coordination of benefits. When the Fund requests this information, it must be returned with all other requested information as soon as possible to avoid any delay in your claims being processed.

HOW COORDINATION OF BENEFITS WORKS

To administer this provision properly, and to determine whether this Plan will reduce its regular benefit, it is necessary to determine the order in which the various plans will pay benefits. Here is the order in which benefits will be determined:

A plan with no provision for coordination of other benefits will be considered to pay its benefit before a plan that contains such a provision.

1. ***Non-Dependent or Dependent***: A plan that covers a person other than as an eligible dependent (e.g., as an employee) will be considered to pay its benefit before a plan that covers the individual as an eligible dependent.

2. ***Dependent Children Covered Under More than One Plan:***
   a) For dependent children covered by both parents' plans, the plan covering the parent whose birthday falls earlier in the year (month and day) pays first if: (i) the parents are married; (ii) the parents are not separated (whether or not they ever have been married); or (iii) a court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for

the child. The plan covering the parent whose birthday falls later in the year pays second.

If both parents have the same birthday, the plan that covered a parent longer pays first. The plan that covered the other parent for a shorter time pays second. A person's year of birth is not used in applying this rule.

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

   If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the Plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the Plan that covers the parent whose birthday falls later in the calendar year pays second.

c) If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the Plans of the parents and their spouses (if any) is:
   - The plan of the custodial parent pays first; and
   - The plan of the spouse of the custodial parent pays second; and
   - The plan of the non-custodial parent pays third; and
   - The plan of the spouse of the non-custodial parent pays last.

d) If the child has employer-sponsored coverage as an active employee through his or her own employment and is also covered through both of his parents, the child's plan pays first and the parents' plan will pay second and third, in accordance with (a) through (c) of this rule, provided that allowable expenses remain.

e) If the child has employer-sponsored coverage as an active employee and is married and also has employer-sponsored coverage through his or her spouse's employment, the child's plan pays first and the spouse's plan pays second. The parents' plan will pay third (and fourth, if applicable), in accordance with (a) through (c) of this rule, provided that allowable expenses remain.

f) If the child is married and has employer-sponsored coverage through his or her spouse's employment, the child's spouse's plan pays first and this Plan will pay second. If the child has coverage through both parents, the parent's plan will pay second and third in accordance with (a) through (c) of this rule, provided that allowable expenses remain.

3. ***Active/Laid-Off or Retired Employee:*** The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the Plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

   If the other plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 2 rather than by this rule.

4. ***Continuation coverage*****:** If a person whose coverage is provided under a right of continuation provided by Federal (COBRA) law or state law also is covered under another plan, the plan covering the person as an employee, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored. If a person has COBRA Continuation Coverage through the Fund and Medicare coverage, Medicare coverage will be primary and COBRA coverage will be secondary, except that Medicare will be secondary if Medicare coverage is due to End Stage Renal Disease, as required by the Medicare regulations.

5. Where none of above establish the order of payment, the plan that has covered the person for the longer period of time will be considered to pay its benefits before the other plan(s).

6. If you are receiving a pension (including a disability pension) from the Pension Plan, you are no longer considered an active employee under this Plan. Any plan that would cover you as an employee is primary and this Plan is secondary. If you do not elect coverage from the other employer, this Plan will coordinate benefits with the other plan anyway. This Plan will pay the excess of covered charges to the extent that the combined payment from both plans does not exceed the amount this Plan would pay alone.

The Fund has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

For the purposes of this Coordination of Benefits section, the word "plan" refers to any group medical policy, contract or plan, whether insured or self-insured, which provides benefits payable on account of medical and/or dental services incurred by the covered person or that provides medical services to the covered person.

How Much This Plan Pays When It Is Secondary

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

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

- The difference between the cost of a semi-private room in a hospital or health care facility and a private room, unless the patient's stay in a private hospital room is determined (by the Plan Administrator it is designee) to be Medically Necessary.
- If the coordinating plans determine benefits on the basis of an Allowed charge amount, any amount in excess of the highest Allowed Charge is not an allowable expense.

- ✧ If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- ✧ If one coordinating plan determines benefits on the basis of an Allowed charge amount and the other coordinating plan provides benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the allowable expense for all plans.
- ✧ When benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

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

Administration of COB

To administer COB, the Plan reserves the right to:

- ✧ Exchange information with other plans involved in paying claims;
- ✧ Require that you or your health care provider furnish any necessary information;
- ✧ Reimburse any plan that made payments this Plan should have made; or
- ✧ Recover any overpayment from your hospital, physician, dentist, other health care provider, other insurance company, you or your dependent.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

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

This Plan follows the customary Coordination of Benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program

and the dental program coordinates only with other dental plans or programs and not with any other medical plan or program. Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits for Class 5 only.

If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on Plan's Allowed charge.

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

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

Spouse, Spousal Equivalent and Dependent Coverage

Each year, the Fund sends out a Coordination of Benefits form to be filled out by each employee's spouse/spousal equivalent and adult children. In order to properly coordinate benefits, this form must be filled out with accurate information in its entirety and returned to the Fund Office as soon as possible. Failure to return the required information may cause a delay in your claims being processed.

COORDINATION WITH GOVERNMENT PROGRAMS

Coordination With Government Programs	
Medicaid	If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second.
TRICARE (Military Health Plan)	If a dependent is covered by both this Plan and the TRICARE Program (formerly known as the Civilian Health and Medical Program of the Uniformed Service or CHAMPUS) that provides health care services to Uniformed Service members, retirees and their families worldwide, this Plan pays first and TRICARE pays second. For an employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this Plan is secondary for active members of the armed services only. If a Covered Individual receives services in a Military Medical hospital or facility on account of a military service-related illness or injury, benefits are not payable by this Plan.
Veterans Affairs Facility Services	If a Covered Individual receives services in an U.S. Department of Veterans Affairs hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If a Covered Individual receives services in a U.S. Department of Veterans Affairs hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan in accordance with regular Fund guidelines.
Other Coverage Provided by State or Federal Law	If you are covered by both this Plan and any other plan provided by any other state or Federal law, the coverage provided by any other state or Federal law pays first and this Plan pays second.

MEDICARE

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

HOW MEDICARE WORKS WITH PLAN BENEFITS FOR ACTIVE EMPLOYEES

If you, your covered spouse, spousal equivalent or dependent child are covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, you may either retain or cancel your coverage under this Plan.

If you, your spouse, spousal equivalent and/or your dependent child are covered by this Plan and by Medicare, and you retain your coverage under this Plan, as long as you remain actively employed, your health care coverage will remain the same, and this Plan pays first and Medicare pays second.

If you cancel your coverage under this Plan, coverage of your spouse, spousal equivalent and/or your dependent child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. Refer to the section on COBRA Continuation Coverage, for further information. The choice of retaining or canceling coverage under this Plan of a Medicare participant is the responsibility of the employee. Neither this Plan nor the employee's employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

If an eligible employee under this Plan becomes totally disabled and entitled to Medicare because of that disability, the eligible employee will no longer be considered to remain actively employed. As a result, once the employee becomes entitled to Medicare because of that disability, Medicare pays first and this Plan pays second. Generally, if an eligible dependent of an eligible employee under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, this Plan pays first for that dependent and Medicare pays second (as long as the dependent remains eligible under the terms of the Plan).

If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of:

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

Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

BENEFITS FOR RETIREES AND DEPENDENTS WHO ARE MEDICARE-ELIGIBLE

Those enrolled in any Part of Medicare may either retain or cancel coverage under this Plan. If a retiree under this Plan is covered by Medicare and cancels coverage under this Plan, coverage for his/her dependents will terminate (but they may be entitled to COBRA Continuation Coverage). Refer to the section on COBRA Continuation Coverage for further information.

Medicare has three parts: Part A, Part B, and Part D. In general:

- ✧ Part A covers hospital services, skilled nursing facilities and Hospice.
- ✧ Part B covers medical services such as physician visits, physical and occupational therapy and diagnostic testing.
- ✧ Part D covers prescription drug expenses.

How much this Plan Pays When it is secondary to Medicare

If you are retired and covered by Medicare Parts A and B, as well as this Plan, Medicare pays first and this Plan pays second. In such cases, you pay the Part A and Part B deductibles and any coinsurance amounts and this Plan pays the amounts you paid for deductibles and coinsurance. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the billed charges of the health care provider.

How much this Plan pays when covered by another active plan and Medicare

If you are retired from this Fund and Medicare eligible and also covered by any other active policy through an actively working spouse or from active employment of your own, the active plan pays first, Medicare pays second and this Fund pays third (and last).

Please be aware that when Medicare is primary, <u>you must follow Medicare guidelines.</u> Secondary coverage under the Fund is limited to Medicare approved charges only.

Once retired, you and your eligible dependents that are eligible or become eligible for Medicare due to age or disability must enroll in Medicare Part B and pay the Medicare premiums and deductibles. This Plan pays benefits secondary to Medicare and **WILL NOT** duplicate hospital and medical benefits available under Medicare for retirees and dependents that are eligible for Medicare. **If you do not enroll in Part B, the Plan will coordinate as if you were enrolled in Medicare.**

When You Are Not Covered by Medicare Parts A and B

You should understand that not enrolling in Medicare Parts A and B will have significant impact on the expenses for which you will be responsible. This is because if you and/or your eligible dependent(s) are eligible for Medicare (e.g., because you are age 65), but choose not to enroll in Medicare Parts A and B, this Plan pays benefits as if it were coordinating with Medicare Parts A and B. Therefore, you will only receive the benefits the Plan would have paid had Medicare Part A or Part B paid benefits first (generally any applicable deductible and/or the 20% Medicare coinsurance for a particular service or supply).

This provision does not apply for Medicare Prescription Drug Benefits (Medicare Part D). You will receive prescription drug benefits from this Fund only if you **DO NOT** enroll in the Medicare Part D Prescription Drug Plan.

Prescription Drug Benefits and Medicare

You and your spouse or spousal equivalent are eligible for retiree prescription drug coverage under this Plan that is the same as the coverage you were eligible to receive when you retired. If you are Medicare-eligible and if you or your spouse/spousal equivalent enroll in the Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Plan with prescription drugs (MA-PD), your (or your spouse's/spousal equivalent's) prescription drug coverage under the General Laborers' Local Unions 472 and 172 of New Jersey Welfare Fund **will end**. Any retiree or dependent enrolled in Medicare Part D **WILL NOT** be eligible to receive benefits for any prescription drugs under the Plan.

Prescription Drug coverage is available to everyone with Medicare through private Medicare prescription drugs plans (often referred to as Medicare Part D). All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. For more information about this Plan's Prescription Drug Benefit and your options for Medicare prescription drug coverage, refer to separate materials provided by the Fund that explain how this Plan's prescription drug coverage compares to Medicare prescription drug coverage.

The Medicare Advantage Program (formerly called Medicare + Choice or Part C) without Prescription Drug Benefits

If an individual is covered by both this Plan and a Medicare Advantage program, and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services in-network when the Medicare Advantage program requires it, this Plan will reimburse all applicable co-payments, deductibles and/or coinsurance. However, if an eligible individual does not comply with the rules of their Medicare Advantage program, including without limitation, approved referral, precertification/preauthorization, case management or utilization of in-network provider requirements, this Plan will **NOT** provide any health care services or supplies or pay any benefits for any services or supplies that the individual receives.

Medicare Private Contracts

Under the law, a Medicare participant is entitled to enter into a Medicare private contract with certain health care practitioners with whom he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If a Medicare participant enters into such a contract, this Plan will pay benefits for health care services and/or supplies the Medicare participant receives pursuant to it, but only up to the amount it would have paid if the provider did participate with Medicare. Therefore, the Plan will pay up to the amount Medicare would have allowed **less** the amounts that would have been paid by Medicare had the provider been eligible to submit the claim to Medicare Part A or Part B. The difference is the patient's responsibility.

THIRD PARTY LIABILITY

ADVANCE ON ACCOUNT OF PLAN BENEFITS

No benefits will be provided under this Plan for medical care for, or received in connection with, and illness, injury or condition for which a third party may be liable or legally responsible by reason of negligence, or an intentional act or breach of any legal obligation, or operation of law, including, but not limited to, any injuries or diseases arising out of employment and/or subject to any Worker's Compensation program or statute.

However, subject to the terms and conditions of this section, the Plan will advance payment on account of Plan benefits until it is determined whether or not a third party is required to pay for those services or supplies.

To ensure that the Plan continues to cover treatments when it appears that the Plan has subrogation rights, the Plan Administrator may request information regarding the cause of an injury or illness. If the requested information is not provided, the Plan reserves the right to suspend payment for those treatments until the information is received.

By accepting an advance on account of Plan benefits, you, your spouse, spousal equivalent and/or any of your dependent children (hereafter called "a Covered Individual") jointly and severally agree that:

- You will hold in trust for the Plan's benefit that portion of the total recovery from any source that is due for payments made or to be made;
- You will, jointly and severally, and immediately, reimburse the Plan out of any and all amounts paid or payable to any or all of you by any third party or that third party's insurer to the extent of the entire amount advanced on account of Plan benefits; and
- The Plan will be subrogated to every Covered Individual's right of recovery from that third party or that third party's insurer to the extent of the entire amount advanced on account of Plan benefits.

The Plan's reimbursement and/or subrogation rights will include all claims, demands, actions and rights of recovery of all Covered Individuals against any third party or insurer, including a workers' compensation insurer or governmental agency, and will apply to the entire amount advanced on account of Plan benefits.

This Plan is granted and the Covered Individual specifically consents to an equitable lien by agreement, or a constructive trust over, and this Plan has the right to reimbursement from, any monies that a Covered Individual receives from or through any third party to the extent of Plan benefits paid or payable by the Plan on behalf of the Covered Individual. The Plan's right to reimbursement, equitable lien and constructive trust extends to any Covered Individual and any individuals or entities that may receive a recovery on behalf of the Covered Individual, such as the Covered Individual's spouse, parents, dependents, heirs, estates, trusts, representatives, trustees, or guardians, including attorneys, agents, successors or assigns.

Motor Vehicle Insurance/Personal Injury Protection (PIP)

All Covered Individuals will maintain or be deemed to maintain automobile and motorcycle insurance for any vehicle they operate or own, in whole or in part, which insurance will include personal injury protection of no less than $250,000. (This insurance is often referred to as "no fault" insurance.) You must choose personal injury protection as your primary insurance.

No benefits will be paid by the Plan for expenses or fees incurred in connection with injuries sustained in an automobile, motorcycle accident, or incident unless the Covered Individual maintains such insurance with personal injury protection of no less than $250,000 and then only to the extent such expenses or fees exceed the above-noted minimum limits of personal injury protection under the Covered Individual's automobile or motorcycle insurance, and/or the insurance available under any other person's automobile or motorcycle insurance who was involved in the accident or incident. No benefits will be paid for such expenses or fees, which are included in the "deductible" clause of the Covered Individual's automobile or motorcycle policy or coinsurance.

In the event such insurance is not available under the laws of the state wherein the Covered Individual resides, or if the laws of such state limit the coverage to something less than $250,000, then the Medical Plan will provide benefits in accordance with this Plan for such expenses, which exceed the maximum amount of protection available in such state.

To the extent that the Medical Plan provides benefits pursuant to this section, the Plan will have a lien and/or right of subrogation against any recovery realized by the Covered Individual because of the acts of a third party and, as a condition of obtaining benefits of this Plan, the Covered Individual will execute an acknowledgement of the Medical Plan's lien against any such recovery obtained by the Covered Individual. All other terms and conditions of this Plan remain in full force and effect.

SUBROGATION

As used in this document, "subrogation" means the right of the Plan to be substituted in place of any Covered Individual with respect to that Covered Individual's lawful claim, demand, or right of action against a third party or insurer who may have wrongfully caused the Covered Individual's injury or illness, which resulted in a payment of benefits by the Plan. A third party who wrongfully caused the Covered Individual's injury or illness is called a "tortfeasor."

The Plan will be subrogated to any right you have against such third persons. You will, in such case, be required to execute certain documents to acknowledge the Plan's lien against such recovery.

The Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its right to recover any amount it advance on account of Plan benefits, and may try or settle any such action or proceeding in the name of and with the full cooperation of the Covered Individuals.

However, in doing so, the Plan will not represent, or provide legal representation for, any Covered Individual with respect to that Covered Individual's damages, to the extent those damages exceed any advance on account of Plan benefits.

The Plan may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any Covered Individual against any third party or that third party's insurer on account of any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual's injury or illness, which resulted in advance by the Plan on account of Plan benefits.

Reimbursement and/or Subrogation Agreement

Every Covered Individual on whose behalf an advance on account of Plan benefits is made, and their legal representative, must execute and deliver to the Plan Administrator an Agreement and Acknowledgement of Lien and Obligation to Reimburse, as well as any and all other agreements, instruments and papers requested by or on behalf of the Plan, and must do whatever is necessary to protect all of the Plan's reimbursement and/or the subrogation rights.

If the Covered Individual is a minor or is otherwise incompetent to execute a reimbursement and/or subrogation agreement, that person's parent (in the case of a minor), spouse, spousal equivalent or legal representative (in the case of an incompetent adult) will execute the agreement on request by or on behalf of the Plan.

If any Covered Individual, or that individual's parent, spouse, spousal equivalent or legal representative, does not execute any such reimbursement and/or subrogation agreement for any reason, that failure to execute the agreement will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's reimbursement and/or subrogation rights if the Plan, at its discretion, makes an advance on account of Plan benefits in the absence of a reimbursement and/or subrogation agreement, and the Plan reserves the right to suspend coverage of the Covered Individual's treatments until the agreement is signed and returned.

Cooperation With the Plan by All Covered Individuals

By accepting an advance on account of Plan benefits, every Covered Individual agrees not to do anything that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights.

By accepting an advance on account of Plan benefits, every Covered Individual agrees to notify and consult with the Plan, its Plan Administrator or designee, before:

- ✧ Starting any legal action or administrative proceeding against a third party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual's injury or illness, which resulted in the Plan's advance on account of Plan benefits; or
- ✧ Entering into any settlement agreement with that third party or that third party's insurer that may be related to any actions by that third party that may have caused or

contributed to the Covered Individual's injury or illness, which resulted in the Plan's advance on account of Plan benefits.

By accepting an advance on account of Plan benefits, every Covered Individual agrees to keep the Plan, its Plan Administrator or designee, informed of all material developments with respect to all such claims, actions, or proceedings.

The Covered Individual and/or his or her representative or attorney will immediately notify the Fund Office upon receiving any monies, award, judgment or settlement offer from any third party or insurer. The Covered Individual and his or her attorney must agree to hold in escrow, in an appropriate attorney trust account, the portion of the total recovery that is due for benefits paid or payable by the Plan, which will not be released from escrow until the Plan has received full satisfaction of its lien and/or provides written consent for such release.

Application of All Recovered Proceeds to Reimburse the Plan

By accepting an advance on account of Plan benefits, every Covered Individual agrees to reimburse the Plan for all such advances, applying any and all amounts paid or payable to them by any third party or that third party's insurer by way of settlement or in satisfaction of any judgment or agreement, regardless of whether the Covered Individual is made whole, and without any reduction for any legal or other expenses incurred by any Covered Individual in connection with the recovery against the third party or that third party's insurer, except as may be expressly agreed to by the Plan at its sole discretion.

The Plan specifically disavows any claim that an eligible employee or dependent may make under any Federal or state common law defense including, but not limited to, the make-whole doctrine and/or the common fund doctrine.

If any Covered Individual fails to reimburse the Plan as required by this section, the Plan may apply any future Plan benefits that may become payable on behalf of all Covered Individuals to the amount not reimbursed.

OVERPAYMENTS

In the event the Fund Office makes a payment error, we will send you an overpayment letter requesting the money back. Failure to reimburse the Health Fund will result in the Fund Office withholding the amounts due for future health benefit claims.

PRIVACY OF YOUR HEALTH INFORMATION

A Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the Heavy and General Laborers' Local Union 472 and Local Union 172 Welfare Fund of New Jersey protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment and is available from the Fund/Plan Administrator. This statement is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

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

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

The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called "Business Associates" to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Under Federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or

with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

This Plan maintains a Notice of Privacy Practices, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, contact the Fund Office. If you have questions about the privacy of your health information or you wish to file a complaint about a privacy issue, contact the Plan's Privacy Official at the Fund Office.

HIPAA USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A. **Use and disclosure of Protected Health Information (PHI):** The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below:

   "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 health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

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

   1. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and co-payments as determined for an individual's claim), and establishing employee contributions for coverage;
   2. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing;
   3. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

"Health Care Operations" includes, but is not limited to:

1. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;
3. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
4. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
5. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers; and
6. Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.

B. The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary. With an authorization, the Plan will disclose PHI to the following: the trustees for use in disability appeals, the fund staff when processing a claim for pension benefits, Contributing Employers, the union, workers' compensation carriers, and the pension and disabilities insurers for purposes related to administration of these plans.

C. For purposes of this section the Board of Trustees of the Heavy and General Laborers' Welfare Fund of New Jersey Local 172 and 472 is the "Plan Sponsor."

   With respect to PHI, the Plan Sponsor agrees to:

   1. Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law;
   2. Ensure that any agents, including their subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
   3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;
   4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the individual;
   5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
   6. Make PHI available to the individual in accordance with the access requirements of HIPAA;
   7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
   8. Make available the information required to provide an accounting of disclosures;
   9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the Plan with HIPAA;
   10. If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and

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

D. The Plan and the Plan Sponsor maintain adequate separation as required by HIPAA. Only the following employees or classes of employees may be given access to PHI:
   1. The Plan Administrator.
   2. Staff designated by the Plan Administrator based on their job title and function. Fund staff have access to individually identifiable health information, including claims information, in the Fund's computer system. Access is determined by the responsibilities of the individual at the Fund.

E. The persons described in Section D may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

F. If the persons described in Section D do not comply with this Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

G. For purposes of complying with the HIPAA privacy rules, this Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and no other plan functions or benefits.

H. The Plan Sponsor has:
   1. Implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan;
   2. Ensured that the adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, is supported by reasonable and appropriate security measures;
   3. Ensured that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
   4. Agreed to report to the Plan any security incident of which it becomes aware concerning electronic PHI.

BREACH NOTIFICATION RIGHTS FOR UNSECURED PROTECTED HEALTH INFORMATION UNDER HIPAA

The Health Information Technology for Economic and Clinical Health (HITECH) Act requires the Plan Sponsor to provide notification to you following the discovery of a breach of your unsecured PHI. In addition, the Plan Sponsor is also required to notify the Department of Health and Human Services (HHS) if there is a breach. Further, if the breach involved more than 500 individuals, the Act requires the Plan Sponsor to provide notification to the media.

For purposes of this section, a breach means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under HITECH, which compromises the security or privacy of the protected health information.

If your unsecured PHI is breached, the Plan Sponsor will notify you without unreasonable delay and in no case no later than 60 calendar days after discover of the breach. Notice will be provided by first-class mail where possible, so it is important to keep the Fund up to date with your current mailing address.

Under HIPAA, you have a statutory right to file a complaint with the Plan Sponsor or the HHS Secretary if you believe that your privacy rights have been violated. The HITECH Act specifically provides that you also have a right to file such a complaint should you feel that the Plan Sponsor has improperly followed the breach notification process.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a participant in Heavy and General Laborers' Local Union 472 and Local Union 172 Welfare Fund of New Jersey, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

You have the right to:

- ✧ 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. These include 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 Pension and Welfare Benefit Administration.
- ✧ Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include 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

You also have the right to:

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who 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 the 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 Plan 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 domestic relations order or a medical child support order, you may file suit in Federal court.

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

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) at:

National Office

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

Nearest Regional Office

Employee Benefits Security Administration
New York Regional Office
33 Whitehall Street, Suite 1200
New York, NY 10004
212-607-8600

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting their website at www.dol.gov/ebsa.

PLAN INFORMATION

Official Plan Name

Heavy and General Laborers' Local Union 472 and Local Union 172 Welfare Fund of New Jersey.

Employer Identification Number

The Employer Identification Number is 22-1481564.

Plan Number

The Plan number is 501.

Type of Plan

The Heavy and General Laborers' Local Union 472 and Local Union 172 Welfare Fund of New Jersey is a Welfare benefits fund administered by a Joint Board of Trustees composed of five union and five employer representatives.

Type of Administration

Medical, hospital, hearing aid, vision, dental, prescription drug and MAP benefits are self-funded. Claims for medical hospital, hearing aid, vision, and dental benefits are self-administered by the Fund. Prescription drug benefits are administered by an independent pharmacy benefits manager (PBM). The PPO and MAP Program are administered by independent organizations. Life insurance benefits are fully-insured through a contract with an independent insurance company. Contact information for the PBM, PPO provider, MAP program provider and the insurance company is shown on the ***Important Contact Information*** sheet provided along with this booklet.

An independent insurance company provides stop-loss insurance that will reimburse the Plan for certain losses in excess of amounts described in the stop-loss insurance policy. The insurer's contact information is shown on the ***Important Contact Information*** sheet provided along with this booklet. Under this policy, the insurer does not insure or guarantee any Plan benefits, has no obligation to pay any Plan benefits, and does not make any other payments to Plan Participants.

Plan Administrator

The name, address and telephone number of the Plan Administrator are:

The Board of Trustees of the Heavy and General Laborers'
Local Union 472 and Local Union 172 Welfare Fund of New Jersey
700 Raymond Boulevard
Newark, NJ 07105
973-589-5050

Plan Administration

The Fund is administered in accordance with Collective Bargaining Agreements and the Trust Agreement entered into with various employers in the heavy and general laborers industry by the Heavy and General Laborers Local Union 472 and Local Union 172 of New Jersey. These Collective Bargaining Agreements require that the employers contribute to the Fund on behalf of each of their covered employees at the fixed rates per straight hour paid, and as specified in the particular Collective Bargaining Agreement.

A copy of any Collective Bargaining Agreement requiring employer contributions to the Welfare Fund can be obtained upon written request to the Plan Administrator and may be examined at the Fund Office. Participants or beneficiaries can request a copy of these agreements in writing.

Sole Authority on Plan Benefits

In carrying out their respective responsibilities under the Plan, the Board of Trustees of the Fund, which acts as the Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan, this SPD and other documents governing the Plan, and to interpret any facts relevant to a benefit determination and determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

No action at law or in equity or otherwise may be brought on any claim or other matter whatsoever against the Plan, the Administrator, or the Board of Trustees, unless all of the required claim procedures and claim appeal procedures under Article XVI of the Plan have been followed and exhausted, nor can such action be brought unless brought within two years from the expiration of the time within which proof of loss is required to be furnished or within the maximum time permitted under the applicable provisions of ERISA. This provision, permitting court action, will not be deemed to extend or reinstitute any claim or cause of action that has expired under the time limits set forth in the Trust Agreement, or in any Plan document or regulations of the Board of Trustees or under any statute if such time limit has already expired.

Source of Contributions

The Heavy and General Laborers' Welfare Fund receives contributions in accordance with Collective Bargaining Agreements between the Employer and the Union.

Funding Medium Benefits

Benefits are provided from the Fund's assets accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement. They are held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

Participating Employers

The Fund Office will provide, upon written request, the information as to whether a particular employer is contributing to this Fund on behalf of employees working under a Collective Bargaining Agreement.

Agent for Service of Legal Process

Agent for service of legal process is the Board of Trustees. Service of legal process may be made upon an individual Plan Trustee or the Plan Administrator at 700 Raymond Boulevard, Newark, NJ 07105. For disputes arising under those portions of the Plan that are insured, service of legal process may be made upon the applicable insurer at the address shown on the ***Important Contact Information*** sheet provided along with this booklet, one of its local offices, or upon the supervisory official of the State Insurance Department.

Plan Year

The Plan year is April 1 to the following March 31.

Plan Administrator's Authority

The Board of Trustees, as the Plan Administrator of the Welfare Fund's benefit programs, has full discretion and authority to make the final decision regarding all areas of Plan interpretation and administration, including eligibility for benefits, the level of benefits provided, or interpretation of Plan language (including this SPD) or administrative procedures. The decision of the Plan Administrator is final and binding on all individuals dealing with or claiming benefits under the Welfare Fund, and if challenged in court, the Fund intends for the Plan's Administrator's decision to be upheld, unless found by a court of competent authority to be arbitrary and capricious.

No participating employer, employer organization or labor organization, nor any individual employed thereby, has authority to answer questions on behalf of the Fund and the Plan. Refer all inquiries to the Plan Administrator.

No Liability for Practice of Medicine

The Board of Trustees or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Board of Trustees, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Discretionary Action

The Board of Trustees expressly reserves the right in their sole discretion:

- To terminate or to amend either the amount or the conditions with respect to any benefits, even though such termination or amendment affects claims that have already accrued.
- To alter or to postpone the method of payment of benefits.
- To amend any other provisions of this Plan, including eligibility and benefits provisions.
- To interpret the provisions of this Plan.
- To apply the provisions of this Plan to the circumstances of any claim.

- ✧ To determine the facts that are relevant to any claims based upon the submissions made to them or to cause additional investigation to be made, as they may deem appropriate.

The Board of Trustees reserves the right to amend, modify or terminate the Benefit Plan in order to maintain the financial integrity of the benefits being provided to eligible participants as defined by the Plan. Such action will be taken at a Trustee meeting properly constituted in accordance with the provisions of the Agreement and Declaration of Trust. The decisions made and implemented by the Trustees will be final and binding on all affected participants.

Amendments to the Plan will be made in writing and become effective on the written approval of the Board of Trustees, or on such other date as may be specified in the document amending the Plan.

Plan Interpretation

Plan benefits for active, retired or disabled participants are <u>not</u> guaranteed. The Board of Trustees and/or its duly authorized designee(s) has the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply, and interpret the Plan, including this SPD and any other Plan documents, and to decide all matters (including financial matters) arising in connection with the operation or administration of this Fund. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

Without limiting the generality of the foregoing, the Board of Trustees and/or its duly authorized designee(s) will have the sole and absolute discretionary authority to:

- ✧ Take all actions and make all decisions (including factual decisions) with respect to the eligibility for and the amount of benefits payable under the Plan;
- ✧ Formulate, interpret, and apply the rules and policies necessary to administer the Plan in accordance with the terms of the Plan;
- ✧ Decide questions, including legal or factual issues, relating to the calculation and payment of benefits under the Plan;
- ✧ Resolve and/or clarify any ambiguities, inconsistencies, and omissions arising under the Plan, including this SPD, the Trust Agreement, or other Plan documents;
- ✧ Process and approve or deny benefit claims; and
- ✧ Determine the standard of proof required in any case.

All determinations and interpretations (including factual determinations) made by the Board of Trustees and/or its duly authorized designee(s) will be binding and final upon all employees, beneficiaries and any other individuals claiming benefits under the Plan.

How Benefits May Be Reduced, Delayed or Lost

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

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

You should also be aware that Fund benefits are not payable for enrolled dependents that become ineligible due to age, marriage or divorce (unless they elect and pay for COBRA benefits, as explained beginning on page 17).

If any plan mistakenly pays a larger benefit than you're eligible for, or pays benefits that were not authorized by this Plan, including to an ineligible person, the Plan may seek any permissible remedy allowed by law to recover benefits paid in error (also refer to the "Subrogation" section beginning on page 113).

Compliance With Federal Law

The Plan is governed by regulations and rulings of the Internal Revenue Service and the Department of Labor, current Federal tax law and the Employee Retirement Security Act of 1974 (ERISA). The Plan will always be construed to comply with these regulations, rulings and laws. Generally, Federal law takes precedence over state law, to the extent state law applies.

Allocation and Disposition of Assets Upon Termination

In order for the Fund to carry out its obligation to provide the maximum possible benefits to all participants within the limits of its resources, the Board of Trustees has the right to take any of the following actions, even if claims that have already accrued are affected:

- ✧ To terminate any benefits provided by these Plan Rules.

- ✧ To alter or postpone the method of payment of any benefit.
- ✧ To amend or rescind any provision of these Plan Rules.

The Plan may be terminated in writing by the Board of Trustees when there is no longer in effect an agreement between the Employer and the Unions requiring payment to the Fund. In the event the Plan terminates, the Trustees, by unanimous agreement and in their full discretion, will determine the disposition of any assets remaining after all expenses of the Plan and Trust have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Plan Administrator (with full power) will continue in such capacity for the purpose of dissolution of the Plan.

GLOSSARY

This Glossary provides definitions of specific terms and words used in this SPD or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: A sudden and unforeseen event as a result of an external or extrinsic source, that is not work-related.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Applied Behavior Analysis (ABA) Therapy: The design, implementation, and evaluation of environmental modifications to attempt to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior. ABA strives to improve speech and social interaction skills and reduce disruptive behavior and includes instruction in a range of skills including speech, motor and socialization. ABA Therapy is a technique that some use for individuals diagnosed with Autism Spectrum Disorder (that refers to disorders defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) manual as autistic disorder, Asperger's syndrome or pervasive developmental disorder). Applied Behavior Analysis Therapy is not a covered benefit.

Balance Billing: A bill from a health care provider to a patient for the difference (or balance) between what this Plan pays and what the provider actually charged. Amounts associated with balance billing are not covered by this Plan, even if the Plan's out-of-pocket maximum limits are reached. See also the provisions related to the Plan's out-of-pocket expenses and the Plan's definition of the Fund's fee schedule. Note that amounts over the Fund's fee schedule do not count toward the Plan's out-of-pocket maximum and may result in balance billing to you. Typically, network providers do not balance bill except in situations of third party liability claims. **Out-of-network health care providers commonly engage in balance billing a Plan participant for any balance that may be due in addition to the amount payable by the Plan. Generally, you can reduce balance billing by using in-network providers.**

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the Fund's fee schedule, after calculation of all deductibles, coinsurance and co-payments, and after determination of the Plan's exclusions, limitations and maximums.

Claims Administrator: The independent person or company retained by the Plan to administer the claim processing and payment responsibilities and other administration or accounting services as specific by the Plan.

Coinsurance: That portion of eligible medical and dental expenses for which the Covered Individual has financial responsibility to pay. In most instances, the Covered Individual is responsible for paying a fixed percentage of covered expenses after the Plan's deductible has been met. Coinsurance amounts are listed in the ***Schedules of Benefits*** in this document.

Concurrent Review: A managed care program designed to assure that hospitalization and health care facility admissions and length of stay, surgery and other health care services are Medically Necessary by having the Utilization Management (UM) Company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or health care facility. Also called "Continued Stay Review."

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two or more health care plans. See the Coordination of Benefits section.

Co-payment; Co-pay: The fixed dollar amount you are responsible for paying when you incur an eligible medical or dental expense for certain services, generally those provided by network health care practitioners, hospitals (or emergency rooms of hospitals), or health care facilities. The services with a Co-pay are listed in the ***Schedules of Benefits*** in this document.

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical/surgical treatment, prescription drugs and dental treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Covered Individual: Any employee, and/or retiree and that person's eligible spouse, spousal equivalent or dependent child (as these terms are defined in the Plan) who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan. A Covered Individual is also referred to as a Plan Participant.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care.

Deductible: The amount of eligible medical or dental expenses you are responsible for paying before the Plan begins to pay benefits. The amount of deductibles is discussed in the medical expense benefits and dental benefits sections of this document.

Durable Medical Equipment: Equipment that can withstand repeated use and:

- Is primarily and customarily used for a medical purpose;
- Is not generally useful in the absence of an injury or illness;
- Is not disposable or non-durable; and
- Is appropriate for the patient's home.

Durable medical equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Emergency Care/Emergency: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Emergency Care. Emergency Care means medical or dental care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical or dental attention could reasonably be expected to result in any of the following:

- ✧ The patient's life or health would be placed in serious jeopardy.
- ✧ There would be a serious dysfunction or impairment of a bodily organ or part.
- ✧ In the event of a behavioral health disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: Unless specifically indicated otherwise, when used in this document, employee refers to a person employed by a Contributing Employer who is on the payroll of the Contributing Employer and is eligible to enroll for coverage under the Plan. An employee does not refer to leased employees, contract workers, and independent contractors. See the eligibility provisions beginning on page 2.

Employer or Contributing Employer: An employer required by collective bargaining agreement or participation agreement to make contributions to the Welfare Fund on behalf of its employees, and the Locals 472 and 172, and their affiliated employee benefit funds, to the extent they agree in writing to make contributions to the Welfare Fund for some or all of their respective employees.

Experimental and/or Investigational: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational or unproven.

The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or unproven in the treatment of that particular condition.

A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was

considered for precertification under the Plan's Utilization Management program, <u>any</u> of the following conditions were present with respect to one or more essential provisions of the service or supply:

- ✧ The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply;
- ✧ The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by Federal law;
- ✧ In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as Experimental and/or Investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
- ✧ With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current Investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will <u>not</u> be considered Experimental and/or Investigational if it is:
    - Approved by the FDA as an "Investigational new drug for treatment use"; or
    - Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or
    - Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was <u>not</u> approved for general use, and the FDA has <u>not</u> determined that such drug should not be prescribed for a given type of cancer.
- ✧ The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III Experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the service or supply was performed, provided or considered for precertification under the Plan's Utilization Management program:**

- ✧ Medical or dental records of the covered person;
- ✧ The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
- ✧ Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply;
- ✧ Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";
- ✧ The published opinions of, but not limited to: the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or clinical policy bulletins of major insurance companies in the US such as Aetna, CIGNA or United Healthcare or MCG, formerly Milliman Care Guidelines or, the American Dental Association (ADA), with respect to dental services or supplies;
- ✧ Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply; and/or
- ✧ The latest edition of "The Medicare National Coverage Determinations Manual."

Fund's Fee Schedule/Allowable Amount/Allowed Charge or Maximum Allowable Fee: means the amount this Plan allows for eligible Medically Necessary services or supplies and will be determined by the Plan Administrator or its designee to be the **lowest** of:

- ✧ With respect to a PPO or participating network health care or dental care provider/facility, the fee set forth in the agreement between the PPO or participating network health care or dental care provider/facility and the PPO network or the Plan.
- ✧ For out-of-network/non-PPO Provider charges, the Fund's Fee Schedule is the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Network providers. This Plan has adopted a Medicare based reimbursement strategy for Non-Network providers located in

the state of New Jersey, where the maximum amount payable by this Plan is 125% of the amount that would have been payable in accordance with Medicare allowable amounts for the state of New Jersey.

- ✧ The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim, including instances where there is no allowable amount established by Medicare for the submitted claim.
- ✧ For an in-network health care provider/facility whose network contract stipulates that they do not have to accept the network discount for claims involving a third party payer, including auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the allowed amount under this Plan is the discounted fee that would have been payable by the plan had the claim been processed as an in-network claim.
- ✧ The health care or dental care provider's/facility's actual billed charge.

In the case where the PPO allowed amount on an eligible claim exceeds the actual billed charges, the participant will pay their coinsurance on the lesser amount, the billed charges, and the Plan will pay their coinsurance on the PPO allowed amount, plus, the Plan will pay the participant's additional coinsurance responsibility on the difference in the PPO allowed amount versus the actual billed charges.

The Plan adheres to the National Correct Coding Initiative (NCCI) edits. Claims will be processed according to NCCI guidelines regardless of how a provider submits a claim. For example, when a provider bills separately for several individual services and NCCI guidelines indicate that these services should be billed under a single CPT-code, the Plan will follow the NCCI edits and pay the claim as a single, bundled claim.

Additionally, the Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted Allowed Charge amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a Utilization Management Company, Claims Administrator, attorney, stop loss carrier,

medical claim-repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Plan will base its payment for covered services for the non-network provider considering the Plan's cost-sharing provisions, in-network/non-network plan design, and any Special Reimbursement Provisions adopted by the Plan.

Any amount in excess of the Fund's fee schedule (also called "balance billing") does not count toward the Plan's annual out-of-pocket maximums. Participants are responsible for amounts that exceed the Fund's fee schedule allowances payable by this Plan.

Habilitative/Habilitation: Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. An example of habilitative services is a physician-prescribed therapy for a child who is not walking or talking at the expected age. Habilitative services are not covered by this Plan.

Handicap or Handicapped (Physically or Mentally): The inability of a person to be self-sufficient as the result of a physically or mentally disabling injury, illness, or condition (such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, or psychosis), and the person is permanently and Totally Disabled in that they are unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months and the condition was diagnosed by a physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. Also refer to the definition of Totally Disabled.

Home Health Care: Intermittent Skilled Nursing care services provided by a licensed Home Health Care Agency as those terms are defined in this section.

Home Health Care Agency: An agency or organization that provides a program of Home Health Care and meets one of the following three tests:

- It is approved by Medicare and/or accredited by The Joint Commission (TJC); or
- It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or

- ✧ If licensing is not required, it meets all of the following requirements:
  - It has the primary purpose of providing a Home Health Care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a physician or Registered Nurse (RN) to the home.
  - It has a full-time administrator.
  - It is run according to rules established by a group of professional health care providers including physicians and Registered Nurses (RNs).
  - It maintains written clinical records of services provided to all patients.
  - Its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.
  - Its employees are bonded.
  - It maintains malpractice insurance coverage.

Hospice: An agency or organization that administers a program of palliative care and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of six months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home Hospice services) or in a home-like setting (Inpatient Hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. "Palliative care" refers to care of a patient whose disease is not responsive to curative treatment and includes control of pain and other symptoms along with psychological, social and spiritual support. The Hospice agency must meet one of the following tests:

- ✧ It is approved by Medicare; or is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- ✧ If licensing is not required, it meets all of the following requirements:
  - It provides 24 hour-a-day, 7 day-a-week service.
  - It is under the direct supervision of a duly qualified physician.
  - It has a full-time administrator.
  - It has a nurse coordinator who is a Registered Nurse (RN) with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
  - The main purpose of the agency is to provide Hospice services.
  - It maintains written records of services provided to the patient.
  - It maintains malpractice insurance coverage.

A Hospice that is part of a hospital, as defined in this section, will be considered a Hospice for the purposes of this Plan.

Hospital: Means a class of health care institutions that is a public or private facility or institution, licensed and operating as a hospital in accordance with the laws of the appropriate legally authorized agency, which:

- Provides care and treatment by physicians and nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises; and
- Provides diagnosis and treatment on an inpatient basis for compensation; and
- Is approved by Medicare as a hospital.

The facility may also be accredited as a hospital by The Joint Commission (TJC). A hospital may include facilities for Behavioral Health treatment that are licensed and operated according to law.

Any portion of a hospital used as an ambulatory surgical/outpatient surgery facility, birth (or birthing) center, hospice, skilled nursing facility, inpatient rehabilitation facility, subacute care facility/long term acute care facility or place for rest, custodial care, or facility for the aged will **not** be regarded as a hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a physician and as compared to the person's previous condition.

Pregnancy of a covered employee or covered spouse will be considered to be an illness only for the purpose of coverage under this Plan. However, infertility is not an illness for the purpose of coverage under this Plan.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An injury to the teeth caused by trauma from an external source. This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for accidental injury to teeth may be payable under oral services.

In-Network Services: Services provided by a health care provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from out-of-network services that are provided by a health care provider that is **not** a member of the PPO.

Medically Necessary:

A. A medical or dental service or supply will be determined to be "Medically Necessary" by the Plan Administrator or its designee if it:
   - ✧ Is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it or a dentist if a dental service or supply is involved;
   - ✧ Is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and
   - ✧ Is determined by the Plan Administrator or its designee to meet <u>all</u> of the following requirements:
     - It is consistent with the symptoms or diagnosis and treatment of an illness or injury;
     - It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility;
     - It is an "Appropriate" service or supply given the patient's circumstances and condition;
     - It is a "Cost-Efficient" supply or level of service that can be safely provided to the patient; and
     - It is safe and effective for the illness or injury for which it is used.

B. A medical or dental service or supply will be considered to be "Appropriate" if:
   - ✧ It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
   - ✧ It is care or treatment that is as likely to produce a significant positive outcome as, <u>and</u> no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

C. A medical or dental service or supply will be considered to be "Cost-Efficient" if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

D. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.

E. A hospitalization or confinement to a health care facility will **not** be considered to be Medically Necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

F. A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a hospital or health care facility or other more costly facility.

G. The non-availability of a bed in another health care facility, or the non-availability of a health care practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is Medically Necessary.

H. A medical or dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, or any hospital or health care facility.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Morbidly Obese/Morbid Obesity: Under this Plan the term means the:

A. Presence of Morbid Obesity that has persisted for at least five years, defined as either:
   - ✧ Body mass index (BMI) (term defined at the end of this definition) exceeding 40; or
   - ✧ BMI greater than 35 in conjunction with any of the following severe comorbidities:
     - Coronary heart disease;
     - Type 2 diabetes mellitus;

- Clinically significant obstructive sleep apnea (as determined by the Plan Administrator or its designee); or
- High blood pressure/hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management);

AND

B. Individual has completed growth (18 years of age or documentation of completion of bone growth).

C. Within the past 24 months the individual has participated in a physician-supervised nutrition and exercise program (including dietician consultation, increased physical activity, and behavioral modification), documented in the medical record. This physician-supervised nutrition and exercise program must meet ALL of the following criteria:

- ✧ Participation in nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists; and
- ✧ Nutrition and exercise program must be six months or longer in duration; and
- ✧ Participation in physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who does not perform bariatric surgery. **Note**: A physician's summary letter is not sufficient documentation. Medical records are required.

Note: *BMI is calculated by dividing the individual's weight (in kilograms) by height (in meters) squared:*

BMI = (weight in kilograms)

divided by (height in meters) times (height in meters)

or compute using the Obesity Education Initiative website: http://www.nhlbisupport.com/bmi/

To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254.

Non-Participating Provider: A health care provider who does not participate in the Plan's Preferred Provider Organization (PPO). Also referred to as non-PPO, out-of-network or non-network.

Nutritionist: means a professional who is qualified by training to evaluate people's nutritional health and needs, who plans food and nutrition programs, helps a person design meals/food choices to promote healthy eating habits and who assists the person in meeting necessary dietary modifications. To be payable by this Plan the professional must be licensed as a Nutritionist, a Certified Nutrition Specialist, or a Certified Clinical Nutritionist, and not be the patient or the parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered employee.

Out-of-Network Services (Non-Network): Services provided by a health care provider that is not a member of the Plan's Preferred Provider Organization (PPO), as distinguished from in-network services that are provided by a health care provider that is a member of the PPO.

Out-of-Pocket Maximum: The maximum amount of coinsurance each covered person or family is responsible for paying during a calendar year before the coinsurance required by the Plan ceases to apply. When the out-of-pocket maximum is reached, the Plan will pay 100% of additional coinsurance related to covered expenses for the remainder of the calendar year.

Partial hospitalization: Treatment of mental, nervous, or emotional disorders and substance abuse (for Class 5 only) at a hospital facility for at least three hours, but not more than 12 hours in a 24 hour period.

Participant: An eligible employee (see the eligibility provisions beginning on page 2) and his or her eligible dependents and beneficiaries.

Participating Provider: A health care provider who participates in the Plan's Preferred Provider Organization (PPO).

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or Plan Administrator.

Plan Sponsor: The Board of Trustees of Heavy and General Laborers' Local Union 472 and Local Union 172 Welfare Fund of New Jersey.

Precertification: Precertification is a review procedure that is performed **before** services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service, admission and/or length of stay in a health care facility is appropriate and Medically Necessary.

Preferred Provider Organization (PPO): An independent group or network of health care providers (*e.g.* hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of Federal law requiring an employee to provide health care coverage for a dependent child, and requiring that benefits payable on account of that dependent child be paid directly to the health care provider who rendered the services or to the custodial parent of the dependent child. Refer to the “Eligibility for Coverage” section.

Retrospective Review: Review of health care services after they have been provided to determine if those services were Medically Necessary and/or if the charges are covered expenses.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a physician and are:

- Intermittent and part-time;
- Generally not exceeding 16 hours a day, and are usually provided on a less-than-daily basis; and
- Require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse.

Examples of skilled nursing care services include, but are not limited to, the initiation of intravenous therapy and the initial management of medical gases, such as oxygen.

Skilled Nursing Facility: A public or private facility, licensed and operated according to law, that primarily provides skilled nursing care and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets all of the following requirements:

- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a skilled nursing facility or is recognized by Medicare as a skilled nursing facility;
- It is regularly engaged in providing room and board and continuously provides 24 hour-a-day skilled nursing care for sick and injured persons at the patient's expense during the convalescent stage of an injury or illness;
- It maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed physician;
- It provides services under the supervision of physicians;
- It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times;
- It maintains a daily medical record of each patient who is under the care of a licensed physician;
- It is not (other than incidentally) a home for maternity care, rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis; and
- It is not a hotel or motel.

A skilled nursing facility that is part of a hospital will be considered a skilled nursing facility for the purposes of this Plan.

Subacute Care Facility: A public or private facility, either free-standing, hospital-based or based in a skilled nursing facility or as a stand-alone facility, licensed and operated according to law and authorized to provide Subacute Care (sometimes called Specialty Care or post-acute care or long term acute care), that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement to the patient's home or to a suitable skilled nursing facility, and that meets ALL of the following requirements:

- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility;
- It maintains on its premises all facilities necessary for medical care and treatment;
- It provides services under the supervision of physicians;

- ✧ It provides nursing services by or under the supervision of a licensed Registered Nurse;
- ✧ It is not (other than incidentally) a place for rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
- ✧ It is not a hotel or motel.

Subacute care facility is sometimes referred to as a specialty hospital or long term care acute facility.

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. When the procedures will be considered to be separate procedures, the following percentages of the Fund's fee schedule will be allowed as the Plan's benefit (once deductible has been satisfied):

Primary procedure	100% of Fund's fee schedule
Secondary through fifth procedures	50% of the Fund's fee schedule
Sixth and additional procedures	25% of Fund's fee schedule

When there are co-surgeons or an assistant surgeon, the following percentages of the Fund's fee schedule will be allowed as the Plan's benefit (once deductible has been satisfied):

- ✧ Co-Surgeons: 75% of Fund's fee schedule (payable for each surgeon).
- ✧ Assistant Surgeon: 20% of the Fund's fee schedule.

Total Disability; Totally Disabled: The inability of a covered employee to perform all the duties of his or her occupation with a Contributing Employer as a result of a non-occupational illness or injury, or the inability of a covered dependent to perform the normal activities or duties of a person of the same age and sex. See the definition of "Handicap."

Transplant; Transplantation: The transfer of whole or partial organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells, cornea, skin, tendon or bone) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.

- ✧ **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.
- ✧ **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are allogenic.
- ✧ **Xenographic/Xenotransplant** refers to transplantation, implantation or infusion of organs, tissues or cells from one species to another (for example, the transplant of an organ from an animal to a human). Expenses related to xenographic services are not covered by this Plan.

Refer to page 57, the "***Schedule of Benefits***" and the "***Medical Plan Exclusions***" section for additional information regarding transplants. Refer also to page 34 for information about precertification requirements.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is not in jeopardy. Examples of medical conditions that may be appropriate for urgent care include, but are not limited to, fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections.

VACATION BENEFITS

The purpose of the Vacation Fund is to provide vacation benefits for all participants in the bargaining unit who work under the Local Unions 472 and 172 Collective Bargaining Agreement, and for whom contributions are made to the Vacation Fund.

Each employer will contribute to the Vacation Fund for each hour worked by each employee covered under the Collective Bargaining Agreement. Each participant will have an individual account set up which reflects contributions received from each employer of the participant. These accounts will be administered through the Heavy and General Laborers' Locals 472 and 172 Welfare Fund of NJ.

Appropriate payroll taxes on the Vacation Fund contributions are deducted in the following manner: the Vacation Fund contributions will be added to your gross pay and all appropriate payroll taxes deducted from said gross pay. After all necessary payroll deductions are made the full amount of the contributions will be forwarded to the Fund's office and applied to your individual account.

Disbursements of Your Vacation Account

Your vacation account balance will be disbursed the beginning of March of each year for the previous year's contributions. If you would like to receive your balance three times a year, March, August and December you must contact the Fund office and complete a "Vacation Option Form". Your selection will remain in force until you request a change in writing.

Payment of Vacation Account Upon your Death

In the event of your death, your vacation account balance and any contributions not yet received by the Funds will be disbursed to the beneficiary designated by you. If no beneficiary was designated, the vacation account balance will be paid to your estate.

In no event will any of the contributions collected by the Fund be used or diverted to any purpose other than specified above.

LEGAL SERVICES BENEFITS

Eligibility for Legal Services Benefits

All employees, spouses/spousal equivalents and dependents who are eligible for benefits under this Plan by meeting the eligibility requirements outlined in the Eligibility section of this booklet are eligible for the applicable Legal Services benefits outlined in this section.

How to Use the Legal Services Benefit and General Rules on its Operation

In the event you wish to make an appointment to consult a lawyer for benefits provided you by the Legal Services Benefit, call or come to the Legal Services offices at:

Laborers Legal Service
604-608 Market Street
Suite 202
Newark, New Jersey 07105
1-800-525-0472
or
1-800-525-0172

At the time of your appointment, you will meet with an attorney who is a member of the legal staff of the Laborers Legal Services or with an attorney from a panel law firm selected by the Legal Services. Your relationship with your attorney will be that of attorney and client. The attorney-client relationship makes all communications between you and your attorney strictly confidential.

The benefit is designed to cover full costs of those legal services provided to you by the Plan and outlined in detail in the following "Explanation of Individual Benefits" section of this booklet. The benefit, however, does not include any costs or expenses other than the time spent by Plan attorneys in a matter upon your behalf. Fines, interest, penalties, court costs, attorney fees awarded to your adversary by a court, the cost of title searches or surveys and amounts for which you may be found liable are also not covered under the benefit.

You are not compelled to use the benefit or attorneys under the benefit. You are free at all times to select an attorney of your own choosing and to make payment to such an attorney for his services. An administrative fee may be charged for the use of an individual benefit. The Laborers Legal Services Office will inform you at the time you contact the office if such a fee applies in your matter.

In instances where two employees are involved in the same matter, neither employee will be entitled to the Benefit. In the event that your dependents seek benefits, other than consultation, you will be required to consent in writing to their use of the benefit.

IN ALL CASES, YOU MUST FIRST CONTACT THE LABORERS LEGAL SERVICES OFFICE BEFORE GOING TO AN ATTORNEY UNDER THE BENEFIT. IF YOU FAIL TO OBTAIN AUTHORIZATION BEFORE GOING TO AN ATTORNEY UNDER THE BENEFIT, THE BENEFIT MAY NOT PAY FOR THE SERVICES YOU RECEIVE.

EXPLANATION OF INDIVIDUAL BENEFITS

CONSULTATION BENEFIT (SIX (6) HOURS PER FAMILY PER PLAN YEAR)

Who is Eligible

All eligible employees, their spouses and their dependents are entitled to this benefit. Spouses are not, however, entitled to any consultation with regard to any matrimonial matter or any matter as to which the employee may have a contrary or conflicting interest.

What is the Benefit

This benefit provides you and your dependents with an opportunity to consult with an attorney for up to six hours per Plan year on any subject of a personal legal nature. A consultation may include a review of documents and the drafting of letters and other documents. If your consultation results in the use of any other individual benefit, that consultation will not reduce the hourly benefit due to you.

How to Obtain the Benefit

To obtain the consultation benefit, simply con-tact the Laborers Legal Services Plan office in person or by telephone (1-800-525-0472 or 1-800-525-0172) and an attorney will confer with you. If further consultation on the matter is required, the attorney will make an appointment for the most convenient future date possible.

LAST WILL AND TESTAMENT, LIVING WILL, AND POWER OF ATTORNEY (ONE (1) OF EACH DOCUMENT AND ONE (1) CODICIL PER PLAN YEAR FOR ELIGIBLE EMPLOYEE AND SPOUSE)

Who is Eligible

All eligible employees and their spouses are entitled to this benefit.

What is the Benefit

This benefit provides you and your spouse with the opportunity to have an attorney draft a Last Will and Testament for each of you. If you already have a Last Will and Testament, the Plan attorney can draft a Codicil to your existing Will. The Wills drafted pursuant to this benefit may also include trusts for the benefit of minor children, although other types of trusts are excluded from coverage. This benefit also provides you and your spouse with the opportunity to have an attorney draft a living will and a power of attorney for each of you.

How to Obtain the Benefit

To obtain the Last Will and Testament benefit, simply contact the Legal Services Plan office for an appointment with an attorney.

REAL ESTATE BENEFIT (ONE (1) SALE AND ONE (1) PURCHASE AND (1) REFINANCING PER FAMILY EVERY TWO (2) PLAN YEARS)

Who is Eligible

All eligible employees and their spouses are entitled to this benefit.

What is the Benefit

This benefit provides you and your spouse with legal advice and representation for the sale or purchase or refinance of a one or two family residence to be used by you and your family as your principal residence. Representation includes the preparation and review of the real estate contract, preparation of deeds, notes, mortgages and closing documents. The attorney will also order and review title searches, recording instruments, and attend the closing. The benefit does not include the payment of any costs by the benefit. The benefit is limited to one sale and one purchase and one refinancing per family every two Plan years.

How to Obtain the Benefit

To obtain the Real Estate benefit, simply contact the Legal Services office for an appointment with an attorney.

DOMESTIC RELATIONS BENEFIT (LIMITATION BASED UPON SPECIFIC SERVICE UTILIZED)

What is the Benefit

This benefit has six components:

1) **Divorce and Annulment.**

Who is Eligible—All eligible employees are entitled to this benefit. Spouses of eligible employees are not entitled to this benefit.

What is the Benefit—This benefit provides you with legal representation where you are the plaintiff or the defendant in either a divorce action or a civil annulment action. This benefit does not cover costs or other expenses incurred by reason of the divorce or annulment action. You must pay the costs and expenses. You are entitled to representation in one such action every three Plan years. Furthermore, you are entitled to a maximum of two divorces or annulment actions over your entire period of eligibility.

How to Obtain the Benefit—To obtain the divorce and annulment benefit, simply contact the Laborers Legal Services office for an appointment with an attorney.

2) **Separation.**

Who is Eligible—All eligible employees are entitled to this benefit. Spouses of eligible employees are not entitled to this benefit.

What is the Benefit—If you or your spouse separate, you will be entitled to representation in the negotiation, preparation, and execution of a separation agreement, also known as a property settlement agreement between you and your spouse. You are entitled to one agreement every three Plan years.

How to Obtain the Benefit —To obtain the separation benefit, simply contact the Laborers Legal Services office for an appointment with an attorney.

3) **Support Action.**

Who is Eligible—All eligible employees are entitled to this benefit. Spouses of eligible employees may be entitled to this benefit if the other party in the action is not an employee and the employee consults to the spouse's use of the benefit. In such a case, the Welfare Fund will count the spouse's use of the benefit against the employee's remaining benefit.

What is the Benefit—This benefit provides you with legal representation where you are either a plaintiff or the defendant in a child or spousal support action commenced in the Family Part of the Superior Court. You are entitled to two such actions every three Plan years.

How to Obtain the Benefit—To obtain the support benefit, simply contact the Laborers Legal Services office for an appointment with an attorney.

4) **Ancillary, Post-Divorce and Post-Separation Matters.**

Who is Eligible—All eligible employees are entitled to this benefit. Spouses of eligible employees may be entitled to this benefit if the other party in the matter is not an employee and the employee consents to the spouse's use of the benefit. In such a case, the Welfare Fund will count the spouse's use of the benefit against the employee's remaining benefits.

What is the Benefit—This benefit provides you with legal representation where you are either the moving party or the responding party in an action involving an economic issue subsequent to your divorce, annulment or separation. For example if, after a divorce, your former spouse seeks additional alimony or child support, you are entitled to representation. Also, if after a divorce, you seek a reduction in the amount of alimony or child support you are paying, you are entitled to representation. This benefit also covers Domestic Violence disputes, but does not cover any criminal complaints arising out of such disputes. You are entitled to one such action every three Plan years.

How to Obtain the Benefit—To obtain the ancillary post-divorce and post-separation benefit, simply contact the Laborers Legal Services office for an appointment with an attorney.

5) **Pre-Marital Agreements.**

Who is Eligible—All eligible employees are entitled to this benefit. Future spouses of eligible employees are not entitled to the benefit.

What is the Benefit—The benefit provides you with representation in the negotiation, preparation, and execution of a pre-marital agreement between you and your future spouse. You are entitled to one agreement every three Plan years.

6) **Juvenile Matters.**

Who is Eligible—All eligible employees and their spouses and dependents are entitled to this benefit.

What is the Benefit—This benefit provides you with legal representation in the defense of a complaint returnable in the Juvenile section of the Family Part of Superior Court. You are entitled to two such actions every three Plan years.

How to Obtain the Benefit—To obtain the juvenile matters benefit, simply contact the Legal Services Plan office for an appointment with a Plan attorney.

ADOPTION BENEFITS (NO LIMITATION)

Who is Eligible

All eligible employees and their spouses are entitled to this benefit.

What is the Benefit

This benefit provides you and your spouse with legal representation in any uncontested adoption proceeding in which you are a party, including the filing of the adoption petition, and the appearance in court.

How to Obtain the Benefit—To obtain the adoption benefit, simply contact the Laborers Legal Services office for an appointment with a Plan attorney.

CHANGE OF NAME BENEFIT (NO LIMITATIONS)

Who is Eligible

All eligible employees and their spouses, and their dependents are entitled to this benefit.

What is the Benefit

This benefit provides you and your dependents with legal representation in any change of name proceeding in which you are a party, including the filing of the complaint and the appearance in court.

How to Obtain the Benefit

To obtain the change of name benefit, simply contact the Laborers Legal Services office for an appointment with an attorney

LANDLORD TENANT MATTERS (NO LIMITATION)

Who is Eligible

All eligible employees and their spouses are entitled to this benefit.

What is the Benefit

This benefit provides you and your spouse with legal representation in any landlord-tenant action where your landlord is seeking to evict you from your residence. This benefit also provides you with legal representation where you seek to evict a tenant from a residential unit that you intend to occupy as your principal residence. Finally, this benefit also covers actions where you seek the return of a security deposit that your landlord has wrongfully withheld.

How to Obtain the Benefit

To obtain the landlord-tenant benefit, simply contact the Laborers Legal Services office for an appointment with an attorney.

DEFENSE OF CIVIL ACTIONS (LIMITATION TWO (2) EACH PLAN YEAR)

Who is Eligible

All eligible employees, their spouses and dependents are entitled to this benefit.

What is the Benefit

This benefit provides you and your dependents with legal representation in defense of any civil action brought against you in Special Civil Part or Superior Court, Law Division where (1) it is a collection action based on a contract and (2) it is not business or investment related (3) it is not a matter usually covered by insurance and (4) it is not a type of matter usually handled by an attorney on a contingent fee basis. Court appearances on matters falling within the jurisdiction of a small claims court are not covered by the plan. The defense of a collection matter is an example of this benefit.

How to Obtain the Benefit

To obtain the defense of civil action benefit, simply contact the Laborers Legal Services office for an appointment with an attorney.

PROBATE ASSISTANCE (LIMITATION ONE (1) EACH PLAN YEAR)

Who is Eligible

All eligible employees and their spouses and dependents are entitled to this benefit. In addition, the person whose Estate is to be administered must also have been an eligible person under this Plan at the time of his or her death.

What is the Benefit

This benefit provides you with legal assistance in obtaining Letters Testamentary, Letters of Administration or a Surrogate's Certificate where the estate is less than the statutory amount to require Letters of Administration, with consultation with respect to the administration of the estate.

How to Obtain the Benefit

To obtain the Probate Assistance benefit, simply call the Laborers Legal Services office for an appointment with an attorney.

EXPUNGEMENT BENEFIT (LIMITATION THREE (3) ACTIONS EVERY FIVE (5) PLAN YEARS)

Who is Eligible

All eligible employees and their spouses and dependents are entitled to this benefit.

What is the Benefit

This benefit provides you with legal representation in any application for the expungement of any criminal arrest or conviction record, including any court appearances.

How to Obtain the Benefit

To obtain the Expungement benefit, simply contact the Laborers Legal Services office for an appointment with an attorney.

REDUCED RATE REFERRALS (NO LIMITATIONS)

Who is Eligible

All eligible employees and their spouses and dependents are entitled to this benefit.

What is the Benefit

This benefit provides you with a referral to an attorney on many matters not covered by the Plan. If the referral attorney accepts the matter, he or she will charge you a fee that is less than his normal rate of pay. The Client (you, your spouse, or your dependent) pays the fee. The Plan does not pay any portion of the fees incurred. An example of this benefit might be a personal injury case where the normal fee would be 1/3 of the recovery but the Reduced Rate Referral fee would be 1/4 of the recovery.

How to Obtain the Benefit

To obtain the Reduced Rate Referral benefit, simply contact the Laborers Legal Services office for a referral from an attorney.

GENERAL EXCLUSIONS FROM THE LEGAL SERVICES PLAN

All legal services provided by the Benefit have been specifically stated and described. Any legal service that has not been stated and described is excluded.

However, to further guide you in your utilization of the benefits of the Legal Services Benefit, this section lists specifically, but without limitation, particular exclusions from the Plan:

- Criminal matters;
- Immigration matter;
- Matters which would commonly be handled by a private attorney on a contingent fee basis, such as personal injury actions;
- Matters where another employee has an opposing interest;
- Matters relating to business, commercial and professional ventures;
- Matters involving disputes with the Welfare Funds, Pension, or Annuity, or any of its employees or agents of such Funds;

- Matters involving disputes with the Board of Trustees or the Executive Director of this Benefit;
- Matters involving your employer;
- Matters involving the Laborers International Union of North America of Union Locals 472 and 172;
- Actions in which money may be awarded by a court with the exception of domestic relations matters and claims to return your security deposit as a tenant;
- Matters involving tax advice or representation in a tax matter;
- Matters involving a claim for Workers' Compensation benefits;
- Class actions, interventions, or Amicus Curiae filings in any controversy;
- Matters pending at the time you became eligible and for which you have retained a private attorney; and
- Appellate court proceedings.

If you have any questions with regard to coverage, benefits or exclusions, please contact the Laborers Legal Services office at 1-800-525-0472 or 1-800-525-0172.

In order to assist eligible persons to utilize this Benefit, procedures for handling and recording grievances have been established as follows.

LEGAL SERVICES GRIEVANCE PROCEDURES

A grievance is defined as any complaint relating to whether a pending or resolved matter has been handled properly, the denial of a benefit, or any other area of disagreement concerning the relationship between the benefit, benefit attorneys and the employee and his dependents under the benefit.

Step 1: You must bring any grievance to the attention of the benefit by submitting the grievance in writing to the Executive Director at the benefit's office at 604-608 Market Street, Suite 202, Newark, New Jersey 07105. Upon receipt of your grievance, the Executive Director will promptly and expeditiously attempt to settle and adjust your grievance to your satisfaction.

Step 2: If you are not satisfied with the results of step 1, your written grievance will be referred to a grievance committee consisting of persons appointed by the Board of Trustees. The grievance committee will under-take an investigation of your grievance and will report its findings to the Board of Trustees. The Board of Trustees will then handle the grievance to its conclusion and will render a decision thereon.

All grievances must be filed within 180 calendar days of the occurrence in order to be considered, provided, however, for good cause shown, the Board of Trustees may make an exception to the 180 calendar limitation if the situation warrants it.

The decision of the Board of Trustees will be final and binding on all parties.

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