Summary Plan Description For C Branch

Welfare Only

Eligibility and Coverage

Who Is Eligible

- To be eligible for benefits, your employer must pay a monthly contribution to the Welfare Fund during a prior month (see **When You Become Eligible for Coverage** below), in accordance with your collective bargaining agreement.

When You Become Eligible for Coverage

- After your employer has made the minimum required contribution in a month, you will be eligible to participate in the corresponding benefit period that begins on the first day of the second month after the contribution is due. Once you become eligible for benefits, you will continue to be entitled to benefits in subsequent Benefit Periods, providing you continue to meet the contribution requirements.

- The following table shows an example of how your eligibility works.

If you work this month	Your employer contribution is due this month	You are eligible for benefits in this month
January	February	April
February	March	May
March	April	June
April	May	July

- ***If your employer contributions are less than the required amount, but more than $0, you may be "balance billed" the difference so that you can maintain your coverage. If $0 employer contributions are received, you may be able to continue coverage under COBRA.***

Your Eligible Dependents

- Coverage is for you and your eligible dependents. Eligible dependents are your:

- Legally married spouse

- Unmarried children under age 19

- Unmarried children under age 23 who are full-time students at an accredited educational institution and who depend on you for their support

- Handicapped children of any age who are chiefly dependent upon you for support and are unable to earn a living because of mental or physical handicap

- Your children are your biological children, legally adopted children from the date of placement in your home, stepchildren who reside with you, and any children for whom you are legally bound to provide full and permanent support.

- A child may be covered until the end of the month in which he or she reaches the age limit (age 19 or
age 23).

- Your spouse or child is not eligible while they are on active duty in the armed forces of any country.

Qualified Medical Child Support Order (QMCSO)

- Your children also include unmarried children under age 19 (or under age 23 if a full-time student), for whom you are required to provide health care coverage under a Qualified Medical Child

Support Order (QMCSO), regardless of where the children reside. A QMCSO is any judgment, decree, or order issued by a court requiring you to provide child support or health care coverage for a child.

Proof of Eligibility

- As a condition of receiving coverage and benefits under the plan, you must comply with reasonable requests for verification of initial and continuing eligibility.

- Married participants may be required to supply proof of marital status. If your child is a full-time student, **you must provide written proof of attendance to the Fund before the start of each semester.**

- If your child is handicapped, you must provide written evidence of the child's handicap within 31 days after his or her attainment of age 19. When required, you must provide proof of the continuation of your child's handicap to the Fund.

If You Do Not Provide the Required Proof

- Coverage will cease if you fail to give proof or fail to have a required examination. Coverage will also cease if your handicapped child would lose coverage for any reason other than reaching the maximum age.

- You must contact the Fund immediately if the eligibility status of your dependents changes for any reason.

If Your Spouse Is a Member

- If both you and your spouse are IUOE Local 542 members, you may not be enrolled as both a member and a dependent, and only one of you may enroll your eligible dependents.

You Must Complete a Census Information Card

- When you become eligible, you will be covered automatically. To cover your eligible dependents, you must complete and return the Census Information Card included in your Welcome Package within 30 days from your date of initial eligibility in order for their coverage to begin on the same day as your own.

- If you do not return your Census Information Card within 30 days of your benefit effective date, coverage for your eligible dependents may be delayed (and will not be provided retroactively).

When You Need to Make Changes

- You may make certain benefit changes during the year only if a change in status occurs (as outlined below). You must notify the Fund office in writing of your request for a change in coverage within 31 days of the change in status, and you must provide proof of the event. Otherwise, coverage will not be provided retroactively. Any change you make must be on account of, and consistent with, the change in status.

- The following are changes in status:

- A change in your marital status (such as marriage, divorce, legal separation, or annulment)

- A change in the number of your dependents for tax purposes (such as birth, legal adoption of your child, placement of a child with you for adoption, or death of a dependent)

- Certain changes in employment status that affect benefits eligibility for you, your spouse, or child(ren), such as: termination of employment, a strike or lockout, the start of or return from an unpaid leave of absence, a change in worksite, a change in work schedule (for example, between full-time and part-time work, decrease or increase in hours)

- Your child no longer meets the benefit plan's eligibility requirements

- Entitlement to Medicare or Medicaid (applies only to the person entitled to Medicare or Medicaid)
- Change to comply with a state domestic relations order or qualified medical child support order pertaining to coverage of your dependent child
- Your, your spouse's, or child's eligibility for COBRA coverage
- A change in your, your spouse's, or child's place of residence
- A significant increase in the cost of coverage or a significant reduction in the benefit coverage under your or your spouse's health care plan
- The addition, elimination, or significant curtailment of a coverage option
- A change in your spouse's or child's coverage during another employer's annual enrollment period when the other plan has a different period of coverage or following a qualified status change under the other employer's plan
- A loss of coverage from a governmental or educational institution program
- For details about benefit options, restrictions, and administrative considerations that apply for specific status changes, contact the Fund office.

Special Enrollment Rights

- If you do not enroll for health care coverage for your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll your dependents in this plan in the future, provided that you request enrollment within 31 days after your other coverage ends.
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment within 31 days of the marriage, birth, adoption, or placement for adoption.

Changes Must Be Consistent

- All changes must be made within 31 days of the event. Any change you make must be consistent with the change in your status or special enrollment event. A change in coverage is consistent with the event if and only if:
- The change in status for you, your spouse, or child results in a gain or loss of eligibility for coverage
- The election change corresponds with that gain or loss of eligibility for coverage
- For example, if you get married and you are eligible for benefits, you should add your spouse to your plan coverage.

Cost of Coverage

- Your employer makes monthly contributions to the Fund on your behalf. These contributions pay for your benefits. The contribution amount is established in the collective bargaining agreement.

▪ The Fund Office will notify you if you become ineligible for benefits.

When Coverage Ends

- Coverage under the Welfare Fund ends for you or a dependent on the:
- Day of your divorce, legal separation, or annulment
- Last day of the month for a child who reaches the limiting age
- First day of the month you or your employer fails to make any required contributions

- You may be eligible to buy continued coverage for yourself and your eligible dependents for a limited time under COBRA (see **COBRA Continuation Coverage** in the **Plan Operation and Rights** section of this SPD).

Medical Plan Highlights

- Here are some key features of your medical plan.

Eligibility	You may be eligible if your employer is making contributions to the Welfare Fund as the result of a collective bargaining agreement.
Eligible Dependents	Your eligible dependents include your spouse and unmarried children under age 19 (under age 23 if full time student at an accredited educational institution) who depend on you for their support.
When Your Coverage Begins	After your employer has made the minimum required contribution in a month, you will be eligible to participate in the corresponding benefit period beginning on the first day of the second month after the contribution is due.
Cost	Your employer makes contributions to the Welfare Fund on your behalf.
Medical Plan	▪ Preferred Provider Organization (PPO) medical/surgical plan through Independence Blue Cross.
What Is a Preferred Provider Organization?	A PPO provides care through a carefully selected network of doctors and hospitals that offer their services at negotiated discount rates. Whenever you need care, you select a provider of your choice. The provider can be in the PPO network (called "in-network") or out of the network (called "out-of-network"). Generally, your out-of-pocket costs are lower when you use an in-network provider.
Claim Submission	Claim submission is generally not required when you use in-network providers. When you use out-of-network providers, you must file claim forms.
When Your Coverage Ends	You will no longer be eligible to participate in the medical plan if your employer contributions to the Welfare Fund on your behalf fall below the minimum required amount.
Questions	▪ For provider directories, call 1-800-810-BLUE ▪ For customer service, call 215-557-7577 (in Philadelphia); 800-626-8144 (outside Philadelphia). ▪ For pre-authorization, call 1-800-332-2566 ▪ For questions about eligibility, call the Fund office at 1-215-542-8211

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Preferred Provider Organization (PPO)

How the PPO Medical Plan Works

- The PPO provides a carefully selected network of doctors, hospitals, and other facilities from which you may choose to provide services to meet your health care needs. Each network provider must meet strict criteria for delivering quality, efficient health care. Network providers agree to treat you at negotiated discount rates. You and the Fund benefit from the cost savings.

- Each time you need care, you decide whether to use a provider who participates in the network (called "in-network") or use providers outside the network (called "out-of-network").

- There are two key features:

- If you stay in-network, you receive the highest level of benefits. Generally, you pay a flat amount, called a copay, for most covered services. The plan pays 100% of the negotiated discount rate, called the "plan allowance," after your copay. Claims are filed for you.

- If you go out-of-network, you receive lower benefits. Generally, the plan pays 70% of the plan allowance after you satisfy the plan deductible. You pay the remaining 30% until your share of the costs reaches the out-of-pocket maximum. In addition to your 30% share, you pay any amount above the plan allowance. You must also file claim forms.

- **Plan Allowance**

This term refers to the amount Independence Blue Cross will pay for a particular covered medical service or supply. In-network providers accept the plan allowance as payment in full (after you pay any applicable copays).

If you receive out-of-network care, you are responsible for paying the difference between the actual charge and the plan allowance if the actual charge is greater. This difference will not be applied toward your out-of-pocket limit for medical expenses.

Note:
If the provider does not participate in the BlueCard network but is a contracting Blue Shield Provider, the plan will pay the contracting Blue Shield allowance. If that allowance is less than the BlueCard allowance, the member is responsible for the difference; the benefit would be paid as an out-of-network benefit, subject to the applicable deductible, copay, and/or coinsurance.

If the provider does not participate or contract under any Blue Cross/Blue Shield arrangement, the plan will pay the BlueCard allowance. The member is responsible for the difference between the allowance amount and the provider's full charge.

Member Services

- Member Services can answer questions about using the PPO network, track your claims, or help you follow the appropriate pre-authorization procedures.

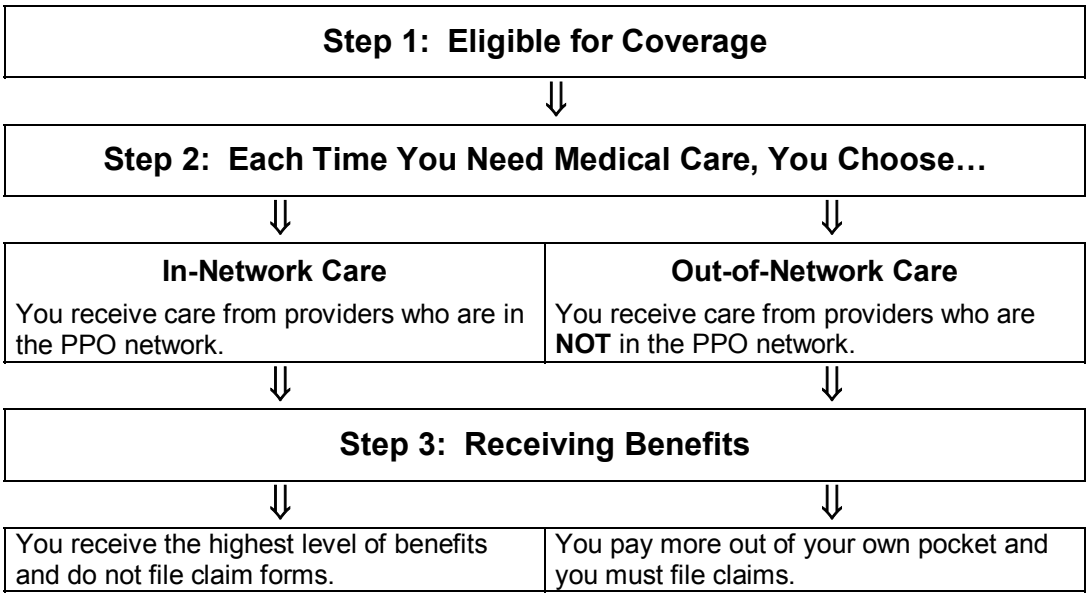
- To reach PPO Member Services, call the number on your ID card, or visit their Web site at www.ibx.com.

Identification Card

- After you are initially eligible for the PPO plan, you will receive an identification (ID) card directly from Independence Blue Cross. This card is for medical benefits, including hospitalization. Be sure to keep your ID card with you—you will need it when you receive care. The ID card also contains phone numbers and other important information about your coverage.

How to Use the PPO Plan

- You decide whether to use providers in the PPO network each time you (or a family member) need care. When you stay "in-network," the plan pays a greater portion of your expenses. Here's how it works:



Choosing a Health Care Provider

- You have the freedom to receive care from any provider or facility. However, you receive the highest level of benefits when you receive care from providers and facilities that participate in the PPO network.

- Since doctors are periodically added to and deleted from the PPO network, you can check with Member Services at the phone number listed on your ID card to find out if a specific provider is in the PPO network. Or, you may go to their Web site at www.ibx.com.

When You're Away from Home For Non-Emergency Care

- If you travel outside the PPO network area, you still have the freedom to receive care from any health care provider.

- You have access to the national BlueCard PPO, a program of participating Blue Cross and/or Blue Shield PPO providers and facilities across the United States. If you receive care from a BlueCard PPO provider or facility, simply show your ID card when you receive care. You will receive the in-network level of benefits, and in general, most of these providers and facilities will file claims for you. Your benefit will be based on the negotiated price passed on to the plan through the BlueCard program.

- If you are outside the PPO network area and receive care from a provider who is not in the BlueCard PPO but is in any other Blue Cross/Blue Shield company's network, your out-of-network benefit will be based on the PPO plan allowance. If you see a provider who does not participate in any Blue Cross/Blue Shield company's network, you will be responsible for the difference between the provider's charge and the plan allowance, in addition to meeting your out-of-network deductible and coinsurance. Remember, you must pay for the care first and then file a claim for reimbursement.

For Emergency Care

- If you need immediate emergency medical care, get the care you need right away. The plan will always cover care and treatment you receive for a true emergency.

- If you receive emergency care from out-of-network providers or providers located outside the PPO network area, your benefits will be paid as if you stayed in-network.

- If you or a covered dependent go to the emergency room and are admitted to the hospital, you must call Member Services within two business days, or as soon as reasonably possible, after the admission. Failure to call Member Services will result in a reduction of benefits.

▪ Call Member Services at the phone number on your ID card within two business days if you are admitted to the hospital on an emergency basis or your benefits will be reduced.

Emergency Care Defined

- Emergency means the sudden and unexpected onset of a medical condition so severe that failure to get immediate medical attention could be expected (by a prudent layperson who possesses an average knowledge of health and medicine) to result in serious:

- Jeopardy to the person's health (or in the case of a pregnant woman, the health of the unborn child);
- Serious impairment to bodily functions; or
- Severe dysfunction of any bodily organ or part.

- Some examples of emergencies are apparent heart attack, severe bleeding, loss of consciousness, and severe or multiple injuries.

Urgent Care

- It's important to know the difference between urgent health care needs and those that are emergencies. Understanding this important difference helps you to know when to go to the hospital emergency room and when to seek care from your doctor.

- An urgent health condition is one that should be treated within 24 hours but does not need immediate medical treatment. If you are not sure your condition is an emergency, or that it may be urgent, call your doctor. He or she knows you and your medical history and can best assess your condition.

When Charges Are Considered Incurred

- A charge will be considered "incurred" on the date a service is provided. You must be covered by the plan on the date the service is provided.

Eligible Expenses

- Eligible expenses are services or supplies that are medically necessary, recommended and approved by the attending physician, and not specifically excluded by the plan. In addition, the expense must have been incurred while the person was covered under the plan, unless specifically provided otherwise.

Sharing the Cost of Services

- While the plan pays most eligible expenses for medical care, you pay a portion. Your share depends on whether you receive in-network or out-of-network care.

- You share the cost of medical care through:

- Copays

- Deductible
- Coinsurance

Copay

- The copay is the flat fee you pay for certain services to in-network providers. See the Schedule of Benefits for applicable copays.

Deductible

- The deductible is the amount of eligible expenses that you must pay each calendar year before the plan starts paying benefits for **out-of-network** care.

- You must meet the individual deductible before the plan pays benefits. If you have family coverage, you must meet the family deductible. The eligible expenses of all covered family members are combined to meet the family deductible. However, no one person may contribute more than the individual deductible amount towards the family deductible.

▪ You must meet the out-of-network deductible before the plan pays benefits. Your individual deductible is $300. The family deductible is $600.

- The following out-of-network services do not count toward your annual deductible:

- Emergency care
- Medical foods
- Pediatric immunizations
- Routine gynecological exams, Pap tests, and mammograms

Coinsurance

- Coinsurance is the percentage of eligible expenses you pay for **out-of-network** care. Generally, the plan pays 70% of eligible expenses after the annual deductible; you pay the remaining 30% until your share of expenses reaches the out-of-pocket maximum. The plan's benefit is based on the plan allowance. In addition to your 30% share, you pay any amount above the plan allowance.

Out-of-Network, Out-of-Pocket Maximum Protects You

- The plan protects you from costly medical expenses by limiting your annual out-of-pocket costs for out-of-network care.

- When the out-of-pocket expenses for one person reach the out-of-network, out-of-pocket maximum, the plan pays 100% of the eligible out-of-network expenses for that person for the remainder of that calendar year. The eligible expenses of all covered family members are combined to determine when you have met the family out-of-pocket maximum. However, no one family member may contribute more than the individual out-of-pocket maximum amount.

▪ Your annual out-of-network, out-of-pocket maximum is $2,000 for an individual, $4,000 for a family.

Expenses Not Counted Toward Your Out-of-Pocket Maximum

- The following charges do not count toward your out-of-network, out-of-pocket maximum:

- The annual deductible
- Charges that exceed the plan allowance
- Penalties you incur for not pre-authorizing certain services as required by the plan (see **You Must Pre-Authorize Certain Care**)
- Emergency Room Copay

Combined Treatment Maximum

- Certain services are limited to a maximum number of visits or days each year. This maximum is applied to the combination of in-network and out-of-network services received.

- The following services are subject to the combined maximum:

- Routine gynecological exam and Pap test
- Physical, speech, and occupational therapies (maximum also applied to the combination of therapies received)
- Cardiac rehabilitation
- Pulmonary rehabilitation
- Restorative services, including chiropractic care
- Outpatient private duty nursing
- Skilled nursing care

Lifetime Maximum

- Generally, the lifetime maximum for in-network care is unlimited. Out-of-network care is limited to a $1,000,000 lifetime maximum. When you reach the lifetime maximum, all benefits will cease.

You Must Pre-Authorize Certain Care

- The plan has a pre-authorization program designed to ensure that you receive quality medical care while avoiding unnecessary treatment. The program's determinations are important in helping you and your physician make decisions about your health care when you need to go into the hospital for treatment or when certain kinds of surgery are recommended.

- In some cases, an alternate treatment may be available that is equally effective but less traumatic for the patient. Pre-authorization also helps determine the most appropriate setting for certain services; the latest innovations in health care enable physicians to provide services in many settings, such as the outpatient department of a hospital, the doctor's office, or on an inpatient basis.

Penalties for Not Pre-Authorizing Care

- Generally, when you use providers in the PPO network, your doctor or the hospital will handle the pre-authorization process for you. However, if you use an out-of-network provider, YOU must call to initiate pre-authorization—even if you use a provider or facility that participates in the BlueCard PPO program.

- If you do not pre-authorize inpatient services or treatment, you will be charged a $1,000 penalty.
- If you do not pre-authorize certain outpatient services or treatment, your benefits will be reduced by 20%.
- If you do not pre-authorize restorative services (including chiropractic care), or physical, speech, and occupational therapies, your benefits will be reduced by 50%.

- Any penalties you incur as a result of not pre-authorizing care will not count toward your out-of-network, out-of-pocket maximum.

When and Where to Call

- **Call Independence Blue Cross at the pre-authorization number listed on the back of your ID card.** You should call at least two days before a scheduled hospital admission or procedure. In case of an emergency, you must call within two business days or as soon as reasonably possible, as determined by Independence Blue Cross.

Procedures that Require Pre-Authorization

- To ensure that you receive the full benefits to which you are entitled, call for pre-authorization for the following services:

- All non-emergency hospital admissions, except for maternity
- Certain outpatient surgical procedures, including:
  - Bunionectomy
  - Cataract surgery (out-of-network only)
  - Laparoscopic cholecystectomy
  - Hemorrhoidectomy
  - Hernia repair (out-of-network only)
  - Arthroscopic knee surgery/diagnostic arthroscopy
  - Ligation and stripping of varicose veins
  - Prostate surgery (out-of-network only)
  - Spinal/vertebral surgery (out-of-network only)
  - Submucous resection (nasal surgery)
  - Tonsillectomy and/or adenoidectomy
- Transplants
- Operative and diagnostic endoscopies
- MRI
- MRA
- PET Scans
- Nuclear Cardiac Studies

- CAT scan
- Outpatient therapies
  - Physical
  - Speech
  - Occupational
  - Cardiac
  - Pulmonary
  - Respiratory
  - Infusion
- Restorative services, including chiropractic care and related services
- Outpatient private duty nursing
- Other facility services
  - Skilled nursing
  - Hospice
  - Home health
  - Birth center
- Non-emergency ambulance
- Rental of durable medical equipment over $100
- Purchase of durable medical equipment over $100
- Prosthetics

If You Receive Treatment after the Pre-Authorization Is Denied

- If you decide to receive treatment after review and written notification that the hospital admission or procedure is not considered medically necessary, benefits will not be provided and you will be financially liable for non-covered charges.

Individual Case Management

- The plan provides individual case management services when you or a covered dependent has a catastrophic illness or injury.

- After your or your covered dependent's condition has stabilized, a medical review specialist will work with you and your physician to identify and arrange services needed to release you or your covered dependent from the hospital as soon as possible, while continuing your attending physician's treatment plan in an uninterrupted manner.

- These services can include a skilled nursing facility, specialized nursing, or home care specific to your condition and must be agreed upon by you and your attending physician as appropriate for your continued treatment.

- Trained specialists are available to help you and your family make decisions on care for costly and complex long-term medical conditions such as cancer or a debilitating accidental injury.

Summary of Medical Plan Benefits

Plan Feature	In-Network	Out-of-Network[1]
Annual Deductible	$0	$300 per person/$600 per family
Out-of-Pocket Maximum	None	$2,000 per person/$4,000 per family
Lifetime Maximum	Unlimited	$1,000,000
Physician Services		
Office Visits to Primary Care	100% after $10 copay/visit	70% after deductible
Office Visits to Specialist	100% after $20 copay/visit	70% after deductible
Preventive Care (for adults and children)	100% after $10 copay/visit	70% after deductible
Pediatric Immunizations	100%	70%, no deductible
Routine Gynecological Exam and Pap test (1 per calendar year for women of any age)	100%	70%, no deductible
Mammogram	100%	70%, no deductible
Hospital Services		
Maternity		
First OB visit	100% after $10 copay	70% after deductible
Hospital	100% after $75 copay per day (up to $375 maximum per admission)	70% after deductible
Inpatient Hospital[2]	100% after $75 copay per day (up to $375 maximum per admission)	70% after deductible
Other Inpatient and Outpatient Services		
Outpatient Surgery[2]	100% after $75 copay	70% after deductible
Emergency Room	100% after $40 copay (copay waived if admitted)	100% after $40 copay (copay waived if admitted)
Outpatient Laboratory	100%	70% after deductible
Outpatient Radiology[2 3]	100% after $20 copay	70% after deductible

[1]Benefits are based on the plan allowance. If the actual charge is greater than the plan allowance, you will have to pay the difference, and these amounts will not be applied to your out-of-pocket maximum.

[2]Certain services require pre-authorization to determine medical necessity. Failure to pre-authorize will result in a $1,000 penalty for inpatient admissions, a 20% penalty for outpatient services, and a 50% penalty for therapy and restorative services. Call the pre-authorization number on the back of your ID card before you receive these services.

[3]You can eliminate the $20 copay by utilizing the HCSC network. See page W-19 for more details.

Summary of Medical Plan Benefits

Plan Feature	In-Network	Out-of-Network[1]
Other Inpatient and Outpatient Services (Continued)		
Skilled Nursing Care[2] (up to 120 days per calendar year)	100%	70% after deductible
Home Health Care[2]	100%	70% after deductible
Hospice[2]	100%	70% after deductible
Therapy Services		
Physical, Speech, Occupational[2] (up to 60 visits combined maximum per calendar year)	Visits 1 to 30: 100% after $15 copay/visit Visits 31 to 60: 100% after $25 copay/visit	70% after deductible
Cardiac Rehabilitation[2] (up to 36 visits per calendar year)	100% after $15 copay/visit	70% after deductible
Pulmonary Rehabilitation[2] (up to 12 visits per calendar year)	100% after $15 copay/visit	70% after deductible
Chemo/Radiation and Renal Dialysis Therapy	100%	70% after deductible
Restorative Services, including chiropractic care[2] (up to 30 visits per calendar year)	100% after $20 copay/visit	70% after deductible
Other Services		
Outpatient Private Duty Nursing[2] (up to 360 hours per calendar year)	100%	70% after deductible
Durable Medical Equipment[2]	100% after $20 copay	70% after deductible
Prosthetics[2]	100% after $20 copay	70% after deductible
Outpatient Diabetic Education	100%	Not covered

[1]Benefits are based on the plan allowance. If the actual charge is greater than the plan allowance, you will have to pay the difference, and these amounts will not be applied to your out-of-pocket maximum.

[2]Certain services require pre-authorization to determine medical necessity. Failure to pre-authorize will result in a $1,000 penalty for inpatient admissions, a 20% penalty for certain outpatient services, and a 50% penalty for therapy and restorative services. Call the pre-authorization number on the back of your ID card before you receive these services.

What the Medical Plan Covers

- This section provides details about the plan's benefits for specific services. Remember, to be covered by the plan, the services must be eligible expenses. Some services are not covered by the PPO plan. See **Medical Expenses Not Covered** for a list of these items.

- For ease of reference, the eligible expenses described in this section are listed alphabetically.

- Contact Member Services at the number shown on your ID card if you have any questions about whether or not a service is covered, or about the plan's benefits for a specific service.

Allergy Treatment

- The plan covers testing for allergic reactions, allergy shots, and other related expenses when medically necessary.

Ambulance

- The plan covers medically necessary local ambulance service from your home (or the scene of an accident or medical emergency) to the hospital. Trips between hospitals or between a hospital and a skilled nursing facility may also be covered. Benefits are paid for transportation to the closest local facility that can provide services appropriate for your condition. If that facility does not exist locally, you will be covered for trips to the closest appropriate facility.

- All non-emergency ambulance services—both in- and out-of-network—must be pre-authorized. Failure to pre-authorize non-emergency ambulance services will result in a 20% reduction in benefits.

Dental Services

- Because most dental services are covered by the dental plan, the medical plan generally doesn't cover dental procedures. However, benefits are paid through the medical plan for:

- Oral surgery for removal of impacted teeth partially or completely covered by bone (but not for surgical extraction of non-impacted teeth or for routine extractions)

- Dental services for accidental injury to the jaws, sound natural teeth, mouth, or face

- Other eligible dental expenses are covered under the Dental plan through *Fidelio*.

Doctors' Visits

- The plan pays benefits for charges for inpatient and outpatient doctors' visits, as well as treatment by specialists. This benefit includes office, home, and hospital or facility visits. Inpatient consultations are limited to one consultation per consulting physician per confinement.

- In-network expenses for home or office visits to your primary physician are covered at 100% after you pay a $10 copay for each visit. Visits to a specialist are covered at 100% after you pay a $20 copay for each visit.

Durable Medical Equipment

- The plan covers the rental (but not to exceed the purchase price) or purchase of certain medically necessary durable medical or surgical equipment.

▪ Pre-authorization is required for all equipment that costs more than $100 to either rent or buy. Failure to pre-authorize will result in a 20% reduction in benefits.

- Some examples of durable medical equipment include, but are not limited to:

- Crutches
- Hospital beds
- Wheelchairs
- Respirators or other equipment for the use of oxygen
- Monitoring devices

Emergency Care

- Emergency care received at either an in- or out-of-network facility is covered at 100% after you pay a $40 copay. The copay is waived if you are admitted. (In a true emergency, benefits are the same for in- and out-of-network care.)

- Follow-up care at the emergency room within 14 days of the original visit is also covered, subject to a $40 copay.

Emergency Defined

- Emergency means the sudden and unexpected onset of a medical condition so severe that failure to get immediate medical attention could be expected (by a prudent layperson who possesses an average knowledge of health and medicine) to result in serious:

- Jeopardy to the person's health (or in the case of a pregnant woman, the health of the unborn child);
- Serious impairment to bodily functions; or
- Severe dysfunction of any bodily organ or part.

- Some examples of emergencies are apparent heart attack, severe bleeding, loss of consciousness, and severe or multiple injuries.

What to Do in an Emergency

- In an emergency, go to the emergency room of the nearest hospital. If you believe your situation is particularly severe, call 911 for assistance.

▪ If emergency care is required that results in a hospital admission, even for less than one day, you (or your doctor or other representative) must call Member Services within two business days of the admission.

Home Health Care

- Home health care is professional care, therapy, and other services that would be covered in a hospital, but are provided in the patient's home instead of a hospital or facility. Generally, the patient must be homebound to qualify for home health care.

- To be covered, the services must be provided by a licensed home health care agency (or hospital program for home health care) and prescribed under a written treatment plan by your doctor.

- Both in- and out-of-network home health care must be pre-authorized. Failure to pre-authorize home health care services will result in a 20% reduction in benefits.

- Eligible home health care services include:

- Part-time or intermittent home nursing care given or supervised by a registered nurse (RN) or licensed practical nurse (LPN), but not for private duty nursing

- Part-time or intermittent home health aide services, mainly for care of the individual, provided the patient is also receiving nursing or therapy services

- Well mother/well baby care following early release from an inpatient maternity stay. Services must be provided within 48 hours after a vaginal delivery (if discharged earlier than 48 hours), or 96 hours after a cesarean birth (if discharged earlier than 96 hours)

- Care within 48 hours following release from an inpatient hospital stay when discharged within 48 hours following a mastectomy

- Physical or speech therapy

- Medical social services

- Certain medical/surgical supplies, when provided along with covered nursing or therapy services, such as occupational therapy or medical social services

- Eligible home health care services do not include services provided by a family member or resident of your home, transportation, dietitian services, maintenance treatment, durable medical equipment or medical appliances, prescription drugs, custodial care, food or home-delivered meals, and/or homemaking services.

Hospice Care

- If you or a dependent becomes terminally ill with a diagnosed life expectancy of six months or less, you might choose hospice care instead of hospitalization in an acute-care facility.

- Hospice care is a coordinated program to meet the physical, psychological, spiritual, and social needs of a dying person and his or her family. You can receive hospice care in a hospice facility or in your own home.

- Both in- and out-of-network hospice care must be pre-authorized. Failure to pre-authorize hospice care will result in a 20% reduction in benefits.

- Covered services include:

- Room and board, if provided in a licensed facility

- Services and supplies for pain control furnished by a hospice facility, hospital, skilled nursing facility or similar institution, a home health care agency, or other licensed facility or agency under a hospice care program

- Up to seven days respite care in a Medicare-approved skilled nursing facility every six months if the hospice considers such care necessary to relieve the primary care givers and when hospice care is provided primarily in the home

- Hospice care services do not include expenses for research studies directed to life-prolonging methods of treatment; personal, financial, or legal counseling (including estate planning and drafting of a will); private duty nursing; and care provided by family members, relatives, and friends.

Hospital Admission Services

Covered Hospital Expenses

- Covered hospital expenses include room and board, plus all medically necessary ancillary services and supplies received in a hospital, including:

- Pre-admission testing
- Semi-private room and board for up to 365 days per calendar year (70 days per calendar year if out-of-network), unless the plan determines a private room is medically necessary
- Special care units, such as intensive or coronary care, when required
- Operating, delivery, and treatment room charges
- Drugs and medications (including intravenous injections and solutions) unless coverable by the prescription drug plan
- Dressings and casts
- Anesthetics and their administration when administered by a hospital employee
- Oxygen and its administration
- Physical, speech, occupational, cardiac rehabilitation, and respiratory therapy, and hydrotherapy
- Newborn nursery care
- Administration of blood and blood plasma (not replaced on the patient's behalf)
- Radiation and chemotherapy
- Other ancillary services performed at and charged by the hospital (except for personal convenience items)

- All hospital confinements—both in- and out-of-network—are subject to pre-authorization and continued stay review. Failure to pre-authorize hospital admissions will result in a $1,000 penalty.

Lab Tests and X-Rays

- The plan covers lab tests and x-rays ordered by a covered provider to diagnose illness or injury.

- Covered expenses include:

- Diagnostic medical procedures, such as electrocardiogram (EKG), electroencephalogram (EEG), and other diagnostic medical procedures approved by the plan
- Diagnostic x-ray, including radiology, magnetic resonance imaging (MRI), ultrasound, and nuclear medicine
- Diagnostic lab and pathology tests
- Allergy testing, including skin and patch tests and immunotherapy
- You must pre-authorize the following procedures:
- Operative and diagnostic endoscopies
- MRI
- MRA
- CAT Scan
- PET Scan
- Nuclear Cardiac Studies

- Failure to pre-authorize the above procedures will result in a 20% reduction in benefits. See Page 10 for details on pre-authorization.

▪

▪ Health Care Solutions Corporation (HCSC)

▪ You can eliminate your copayment on diagnostic procedures if you utilize the Health Care Solutions Corporation (HCSC) network for diagnostic testing instead of the Blue Cross/Blue Shield network. Simply call HCSC at **1-800-655-8125** and they can find a provider that's convenient for you. You can also visit the HCSC website at www.HCSCorp.net

Maternity (Female Member and Spouse of Member Only)

▪ The plan's coverage for maternity care includes medical and surgical services and care at a hospital or freestanding birthing center during the term of pregnancy, upon delivery, and during the postpartum period.

▪ In-network pre- and post-natal visits are covered at 100% after you pay a $10 copay for the first visit only. Other covered maternity expenses—including all out-of-network care—are subject to regular plan deductibles and coinsurance.

▪ Coverage is provided for:

- Pre- and post-natal care
- Normal deliveries
- Spontaneous abortions (miscarriages)
- Cesarean sections
- Elective termination of pregnancy
- Complications of pregnancy
- Newborn nursery care

Baby BluePrints®

▪ Baby BluePrints is a maternity program offered through Independence Blue Cross that is designed to identify possible risk factors early in pregnancy. Through evaluation, education, and intervention, the Baby BluePrints nursing staff works with your doctor or certified midwife to reduce the risk of complications of pregnancy.

▪ Ask your doctor about enrolling in Baby BluePrints at your initial prenatal visit. Or, call 1-800-598-BABY Monday through Friday, 8:30 a.m. – 5:00 p.m.

Newborns' and Mothers' Health Protection Act

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

Organ/Tissue Transplants

▪ The plan will pay benefits for transplanted human organs, bone marrow, or tissue for covered plan members. Benefits are also provided for services directly related to the transplantation, including

examination of the transplanted organs, marrow, or tissue, and the processing of blood provided to the recipient.

- When both the recipient and the donor are covered under the plan, each is entitled to plan benefits.

- When only the recipient is covered under the plan, both the recipient and the donor are entitled to plan benefits. The plan will not pay recipient or donor benefits for services for which benefits are provided or available from any other source. This includes, but is not limited to, other insurance coverage or any government program. Donor benefits apply toward the covered recipient's deductible and applicable benefit maximums.

- When only the donor is covered under the plan, no benefits are provided to the recipient. The plan will not pay donor benefits for services for which benefits are provided or available from any other source. This includes, but is not limited to, other insurance coverage or any government program.

- All in- and out-of-network transplants must be pre-authorized. Failure to pre-authorize transplant services will result in a $1,000 penalty for inpatient services, and a 20% reduction in benefits for outpatient services.

- The plan will not cover:

- Experimental or investigational organ transplants, as determined by Independence Blue Cross
- The purchase price of an organ or tissue when sold rather than donated to a covered recipient

Other Medical Services and Supplies

- The plan covers the following medical services/supplies:

- Surgical supplies
- Blood plasma or whole blood not replaced by or for the patient
- Chemotherapy
- Radiation therapy
- Infusion therapy (pre-authorization required)
- Dialysis treatment
- Anesthesia
- Oxygen and other gases and their administration
- Diabetic equipment and supplies (pre-authorization required for the purchase of equipment over $100), unless coverable by the prescription drug plan
- Liquid nutritional products (also called "medical foods") specifically formulated to treat one of the following genetic diseases:
  - Phenylketonuria
  - Branched-chain ketonuria
  - Galactosemia
  - Homocystinuria
-

- Note: No deductible applies to covered medical foods as described above

- Nutritional formulas that are a covered person's sole source of nutrition, as determined by Independence Blue Cross, and if:
  - Administered through a tube; or

– For an infant or child suffering from severe systemic protein allergy that is resistant to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas

Outpatient Diabetic Education Program

- The outpatient diabetic education program provides professional counseling about the medical and nutritional needs of diabetics. If your doctor certifies that you or your covered dependent needs education about diabetes, the plan will pay 100% of eligible expenses for in-network care.

- Eligible expenses include, but are not limited to:

- Initial assessment
- Nutritional counseling
- Monitoring
- Prevention and treatment of complications for chronic diabetes (i.e., foot, skin, and eye care)
- Use of community resources

- To qualify for benefits, the program must be provided by an in-network facility or ancillary provider and meet the requirements of Independence Blue Cross. These requirements are based on the certification programs for outpatient diabetic education developed by the American Diabetes Association and the Pennsylvania Department of Health.

Outpatient Private Duty Nursing

- To be covered, the services must be ordered by your physician and provided by a registered nurse (RN) or licensed practical nurse (LPN). The nurse may not live in your home or be a member of your family.

- All in- and out-of-network outpatient private duty nursing services must be pre-authorized. Failure to pre-authorize outpatient private duty nursing will result in a 20% reduction in benefits.

Outpatient Therapy Services

- The plan covers physical, speech, and occupational therapy; cardiac rehabilitation; pulmonary rehabilitation; and respiratory therapy. In-network therapy is covered at 100% after you pay a $15 copay per visit. Visits 31 through 60 for physical, speech, and occupational therapy are covered at 100% after you pay a $25 copay.

- To be covered, outpatient therapy must be prescribed by a physician to promote your recovery from an illness or injury and performed by a registered, licensed therapist or other approved provider, as determined by Independence Blue Cross.

- Pre-authorization is required for all in- and out-of-network outpatient therapy services. Failure to pre-authorize outpatient physical, speech, and occupational therapy will result in a 50% reduction in benefits. Failure to pre-authorize outpatient cardiac, pulmonary, and respiratory therapy will result in a 20% reduction in benefits.

- In some cases, combined treatment maximums (annual limits) apply:

- Outpatient physical, speech, and occupational therapy is limited to 60 visits per calendar year for in- and out-of-network therapy combined. The limit applies to the combination of therapies

- Outpatient cardiac rehabilitation is limited to 36 visits per calendar year for in- and out-of-network therapy combined

- Outpatient pulmonary rehabilitation is limited to 12 visits per calendar year for in- and out-of-network therapy combined

Preventive Care Benefits

- Preventive medical services aid in the early detection of more serious and costly medical problems. The plan covers the following services:

Adult Preventive Care

- In-network adult preventive care is covered 100% after you pay a $10 copay per visit. Out-of-network adult preventive care is covered at 70% after you meet the deductible.

- Covered adults age 18 and older are eligible for a preventive exam according to the schedule below. Adult preventive care services generally include a physical exam, medical history, height and weight measurement, and counseling. Blood and urine screening, other diagnostic procedures, and certain immunizations are included at specified intervals, as determined by Independence Blue Cross. (For details, contact Independence Blue Cross at the number on your ID card.)

For adults…	Plan covers one exam…
Age 18 through age 21 **and** age 40 and older	every year
Age 22 through age 39	every 3 years

Gynecological Exams and Mammograms

- In-network annual gynecologic exams and Pap tests are covered 100%. Annual mammograms are also covered 100% beginning at age 40. Out-of-network care for these services is covered at 70% with no deductible.

- Mammograms for symptomatic reasons or with a medical diagnosis are subject to regular plan provisions.

Well-Child Care

- Routine immunizations are covered 100% for dependent children when you use in-network providers (70% with no deductible for out-of-network providers)

- Well-child care for children under age 18 is covered at 100% after you pay a $10 copay per visit when you use in-network providers (deductible and 70% coinsurance apply if out-of-network), according to the schedule below. Well-child care services generally include a physical exam, medical history, height and weight measurement, and counseling. Blood and urine screening may be included at specified intervals, as determined by Independence Blue Cross.

For children age…	Plan covers one exam every…
Less than 6 months	2 months
Age 6 months through age 17 months	3 months
Age 18 months through age 23 months	6 months
Age 2 years through age 17	12 months

Prosthetic Devices

- The plan covers the initial purchase, fitting, necessary adjustments, and repairs of prosthetic devices that are used as a replacement or substitute for a missing body part.

- Replacement costs for new prosthetic devices are payable only for covered dependent children due to normal body growth when medically necessary.

- All prosthetic devices costing over $100 must be pre-authorized. Failure to pre-authorize prosthetic devices will result in a 20% reduction in benefits.

Restorative Services

- Restorative services are intended to restore function of a body part. Such treatment generally involves neuromuscular training as a course of treatment over a period of weeks or months.

- Examples of restorative services include, but are not limited to:

- Spinal manipulation
- Therapy treatment of functional loss following foot surgery
- Treatment of oculomotor dysfunction

- In-network care is covered 100% after you pay a $20 copay. Out-of-network care is covered at 70% after you meet the annual deductible. Restorative services are limited to 30 visits per calendar year.

- All restorative services must be pre-authorized. Failure to pre-authorize will result in a 50% reduction in benefits.

Skilled Nursing Facility

- Skilled nursing facilities provide closely supervised medical care; physical, occupational, and speech therapy; diagnostic and therapeutic services of a hospital; and other daily services to patients who do not need complete inpatient hospital services but are not well enough to be home. Coverage will be based on whether treatment in a skilled nursing facility is medically necessary and appropriate.

- Benefits are limited to a maximum of 120 days per year for in- and out-of-network care combined. Physician visits during a skilled nursing facility confinement are limited to two visits during the first week of confinement, and one visit each week thereafter.

- The plan will not pay benefits:

- Once the patient can no longer improve from treatment

- For skilled nursing facility care that is intended solely to assist the patient with daily living or for the patient's convenience

- For skilled nursing facility care for alcohol or drug abuse or mental illness

- Pre-authorization is required for all admissions to a skilled nursing facility. Failure to pre-authorize will result in a $1,000 reduction in benefits.

Surgery

- The plan covers inpatient and outpatient surgical charges, which include diagnosis, treatment, and related pre- and post-operative care. This includes visits by the surgeon before and after surgery. If necessary, and when provided by the hospital, the plan will also cover the charges of a surgical assistant and an anesthesiologist.

- If more than one surgical procedure is performed by the same provider during the same operative session, the plan will pay for the highest-paying (primary) procedure only. No allowance will be made for additional (secondary) procedures performed during the same operative session, unless Independence Blue Cross determines an additional allowance is warranted.

- In addition to all medically necessary surgery, covered surgical procedures include routine newborn circumcisions, voluntary surgical sterilization, and surgery to reverse a sterilization procedure.

- Surgical procedures that are cosmetic in nature are covered by the plan only when performed to correct a condition resulting from an accident, or to correct functional impairment resulting from a covered disease, injury, or congenital anomaly or when mastectomy-related.

- For elective (non-emergency) surgery, the plan's benefits also cover second surgical opinions (and a third consultation if the first two opinions conflict). The second (and third) opinion must be performed and billed by a professional provider other than the one who recommended the surgery.

- Certain in- and out-of-network surgical procedures require pre-authorization. See **Procedures that Require Pre-Authorization** earlier in this summary for a list of procedures that must be pre-authorized. Failure to pre-authorize surgical procedures as required will result in a 20% reduction in benefits.

Women's Health and Cancer Rights Act

- Medical plans are required by law to provide the following benefits to women in connection with a mastectomy:

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

- Surgery and reconstruction of the other breast to produce a symmetrical appearance

- Prostheses and treatment of physical complications of all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes)

- Coverage for breast reconstruction and related services are subject to the same deductibles, copays, and/or coinsurance amounts that apply to other benefits under the plan.

Medical Expenses Not Covered

- The PPO plan does not cover services, supplies, or charges that are:

- For medical and hospital services and supplies for injuries resulting from a motor vehicle accident (A motor vehicle is a self-propelled vehicle, operated or designed for use on public roads)

- Not medically necessary and appropriate, as determined by Independence Blue Cross (see the **Definitions** section)

- Not billed and performed by a provider properly licensed and qualified to render the medically necessary treatment, service, or supply

- Experimental or investigative in nature (see the **Definitions** section)

- Incurred prior to your effective date of coverage in the plan

- Incurred after your coverage terminates, unless specifically provided for in this description

- For any loss sustained or expenses incurred during military service while on active duty, or as a result of enemy action or act of war, whether declared or undeclared

- That you have no legal obligation to pay

- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group

- Where payment has been made by Medicare when Medicare is primary or would have been made if you had applied for Medicare and claimed Medicare benefits; however, this exclusion will not apply when the Fund is obligated by law to offer you all the benefits of the plan, and when you elect this plan as primary coverage

- For any illness or injury eligible for or covered by any federal, state, or local government, Workers' Compensation Law, or Occupational Disease Law or Act (this exclusion applies whether or not you claim the benefits or compensation)
- For any occupational injury or illness
- To the extent benefits are provided by the Veteran's Administration or by the Department of Defense for members of the armed forces of any nation while on active duty
- For drugs or medicines covered or coverable under a freestanding prescription drug program
- Rendered by a provider who is a member of your immediate family ("immediate family" means the member's spouse, parent, child, stepchild, sibling, or in-laws, including mother, father, sister, brother, daughter, or son-in-law)
- Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program and are provided through a hospital or university
- For ambulance services, except as specifically provided for in this description
- For surgical procedures for cosmetic purposes that are done to improve appearance and from which no improvement in physiologic function can be expected; however, benefits are payable to correct a condition resulting from an accident, or to correct functional impairment resulting from a covered disease, injury, or congenital anomaly. This exclusion does not apply to mastectomy-related charges as provided for in this description
- For telephone consultations, for failure to keep a scheduled visit, or for completion of a claim form
- For music therapy
- For marriage counseling
- For custodial care, domiciliary care, or rest cures
- For equipment costs related to services performed on high cost technological equipment as defined by Independence Blue Cross, such as, but not limited to, computed tomography (CT) scanners, magnetic resonance imaging (MRI) scanners, and linear accelerators, unless the facility that has the equipment has been approved under Independence Blue Cross' certificate of need process, if applicable, and/or is approved by Independence Blue Cross
- For treatment of temporomandibular joint (TMJ) syndrome, also known as craniomandibular disorders (CMD) with intra-oral devices, or any other non-surgical method to alter vertical dimensions
- Directly related to the care, filling, removal, or replacement of teeth, the treatment of injuries to, or diseases of, the teeth, gums, or structures directly supporting or attached to the teeth; these include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy, bone grafts, or services related to the placement of dentures or dental implants, and treatment of periodontal disease, unless otherwise listed as covered in this description
- For routine palliative or cosmetic foot care including flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone surgery), calluses, toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet
- For supportive devices of the foot (orthotics), except for podiatric appliances for the prevention of complications associated with diabetes
- For hearing aids or examinations or tests for the prescription or fitting of hearing aids
- For any treatment leading to, or in connection with, transsexual surgery, except for illness or injury resulting from such surgery
- For assisted fertilization techniques—these include, but are not limited to, artificial insemination, in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), and zygote intra-fallopian transfer (ZIFT)
- For treatment of sexual dysfunction not related to organic disease, except for sexual dysfunction resulting from an injury

- For treatment of obesity, except for surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height, and sex
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness or exercise equipment, radio and television, beauty/barber shop services, guest trays, wigs, chairlifts, stair glides, elevators, spa or health club memberships, whirlpool, sauna, hot tub or equivalent device, whether or not recommended by a provider
- For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses or any vision services
- For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy, and all related services
- For preventive services, except as specifically provided for in this description
- For weight reduction
- For premarital blood tests
- For diagnostic screening examinations, except for mammograms and preventive care as specifically provided for in this description
- For acupuncture
- For travel, whether or not it has been recommended by a professional provider or if it is required to receive treatment from an out-of-area provider
- For immunizations for employment purposes or for travel
- For care in a nursing home, home for the aged, convalescent home, school, institution for retarded children, or custodial care in a skilled nursing facility
- For counseling or consultation with a patient's relatives, or hospital charges for a patient's relatives or guests, except as may be specifically provided by the plan
- For medical supplies such as, but not limited to, thermometers, ovulation kits, early pregnancy or home pregnancy testing kits, and home blood pressure machines, except for covered individuals with pregnancy-induced hypertension
- For amino acid supplements, appetite suppressants, or nutritional supplements. Benefits are not provided for basic milk, soy, or casein hydrolyzed formulas for the treatment of lactose intolerance, milk protein intolerance, milk allergy, or protein allergy. This exclusion does not apply to medical foods and nutritional formulas as specifically provided for in this description
- For inpatient private duty nursing services
- For any care related to autistic disease of childhood, pervasive development disorders, attention deficit disorder, learning disabilities, behavioral problems, or mental retardation that extends beyond traditional medical management; or treatment or care to effect environmental or social change
- For charges incurred for expenses in excess of benefit maximums or allowable charges as specifically provided for in this description
- For research studies
- For maintenance of chronic conditions, injuries, or illness when response to treatment has reached the maximum therapeutic level, no additional functional improvement can be demonstrated or anticipated, and continuation of the service will be of no therapeutic value
- For cognitive rehabilitative therapy (this is a therapeutic approach designed to improve cognitive functioning after central nervous system injury or trauma. It includes therapy methods that retrain or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning, and problem solving. It utilizes tasks designed to reinforce or reestablish previously learned patterns of behavior or to establish new compensatory mechanisms for the impaired neurologic system)
- For any other service or treatment, except as specifically described in this description

Filing Medical Claims

In-Network Claims

- **If you use an in-network provider, you do not file claims**. PPO providers file in-network claims on your behalf. You simply need to bring your ID card with you when you go to the doctor or hospital, and show it when you check in. Keep in mind, you will be responsible for your copay at the time of the doctor's office visit.

- You may be asked to fill out a member information form when you are there. Once you supply the necessary information, your doctor or hospital takes care of filing the claim directly.

Out-of-Network Claims

- **If you go to an out-of-network provider, you may need to file your own claim**. This is because some doctors and hospitals are not set up to file claims directly. However, some out-of-network providers may submit the claim directly and then bill you for any deductible or coinsurance that is due.

- When you go to the doctor or hospital, you should bring your ID card with you. In some cases you may have to pay first for the expense and then file your claim for reimbursement.

- Your ID card will contain the address for submitting claims if your provider will agree to file the claim for you.

- To file a claim, send the original provider bill to Independence Blue Cross. The bill should include:

- The provider name and address
- Date of service
- Patient name
- Type of service and charges
- Diagnosis
- The member's name and Social Security number
- Doctor's certification for purchase/rental of durable medical equipment
- The Fund's group number
- Send claims to Independence Blue Cross at the address on your I.D. card.

- If you have already paid the bill, include proof of payment so that any payment will be made to you.

- You should try to file claims within **20** days of incurring the expense. In any case, all medical claims must be filed no later than two years following the date you incur an eligible charge. Claims received after that time will not be considered for payment.

- Your claim will be processed as soon as administratively possible.

Information Request Form May Be Sent to You for Certain Claims

- If your claim is missing important information needed for processing, you will be sent a form that you must complete and return to the claim administrator. **Failure to complete and return this form will result in the charges being considered ineligible**.

Coordination of Benefits

- See Coordination of Benefits in the **Other Important Information** section if you are covered by more than one group plan (for example, as an IUOE Local 542 member and as your spouse's dependent under another employer plan).

If Your Claim Is Denied

- The medical plan has a specific claims review procedure for appealing denied medical claims. Generally, you must appeal a denial of benefits within 180 days. Special procedures apply for urgent and pre-service health care claims.

- See the **Plan Operation and Rights** section for details on how to appeal a denied claim.

Definitions

- This section contains definitions of some commonly used plan terms.

Ambulatory Surgical Facility

- "Ambulatory surgical facility" is a facility with an organized staff of physicians which is licensed as required and which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health Care, Inc., or by Blue Cross/Blue Shield and which:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis

- Provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility

- Does not provide inpatient accommodations

- Is not, other than incidentally, a facility used as an office or clinic for the private practice of a professional provider

Birth Center

- A "birth center" is a facility approved by Blue Cross/Blue Shield that is:

- Licensed as required in the state where it is located

- Primarily organized and staffed to provide maternity care

- Under the supervision of a physician or a licensed certified nurse midwife

Case Management

- "Comprehensive case management" programs serve individuals who have been diagnosed with a complex, catastrophic, or chronic illness or injury. The objectives of case management are to facilitate access by the patient to ensure the efficient use of appropriate health care resources, link patients with preventive health care services, assist providers in coordinating prescribed services, monitor the quality of services delivered, and improve patient outcomes. Case management supports patients and providers by locating, coordinating, and/or evaluating services for covered participants who have been diagnosed with a complex, catastrophic, or chronic illness and/or injury across various levels of sites of care.

Coinsurance

- "Coinsurance" is the percentage of covered charges you pay for covered services. For example, the plan pays 70% of most out-of-network expenses and you pay 30% as coinsurance, after you pay the deductible.

- Coinsurance for most expenses is limited each calendar year (see **Out-of-Network, Out-of-Pocket Maximum Protects You**).

Copay

- "Copay" is a flat dollar amount you pay at the time a service is received. For example, you pay a $10 copay at the time of an in-network non-specialist doctor's office visit.

Covered Service

- A "covered service" is a service or supply specified in this summary or the insurance contract as covered by the plan.

Custodial Care

- "Custodial care" means care provided primarily for maintenance of the patient or care designed essentially to assist the patient in meeting his or her activities of daily living, and that is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

- Custodial care includes, but is not limited to, help with walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications that do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

Deductible

- "Deductible" is the specified amount of covered charges for covered services that you must pay each year for out-of-network care before the plan begins to pay medical benefits.

Durable Medical Equipment

- "Durable medical equipment" is equipment that:

- Can withstand repeated use
- Is primarily and customarily used to serve a medical purpose
- Generally is not useful to a person in the absence of an injury or illness
- Is appropriate for use in the home

Eligible Providers

- "Eligible providers" include the following:

- Facility Providers—a "facility provider" is an institution or entity licensed, where required, to provide care, including a:
  - Hospital
  - Ambulatory surgical facility
  - Birth center
  - Freestanding dialysis facility
  - Freestanding ambulatory care facility
  - Home health care agency
  - Hospice
  - Non-hospital facility
  - Rehabilitation hospital
  - Residential treatment facility

- Short procedure unit
- Skilled nursing facility

- Professional Providers—a “professional provider” is a person or practitioner licensed where required and performing services within the scope of such licensure, including a:
  - Certified registered nurse
  - Chiropractor
  - Dentist
  - Independent clinical laboratory
  - Nurse midwife
  - Optometrist
  - Physical therapist
  - Physician
  - Podiatrist
  - Psychologist
  - Audiologist
  - Speech-language pathologist
  - Teacher of the hearing impaired
- Ancillary Providers—an “ancillary provider” is an individual or entity that provides covered services, supplies, and equipment, including but not limited to:
  - Home infusion therapy services
  - Durable medical equipment
  - Ambulance services

Experimental or Investigative

- “Experimental” and/or “investigative” means a drug, device, medical treatment, or procedure as follows:

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

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

- If reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study, or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis; or

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

- Any drug which the FDA has determined to be contraindicated for the specific treatment for which it is prescribed.

▪ If you receive Experimental or Investigative treatment, **you will be responsible for the cost of the treatment**. You or your physician should contact Independence Blue Cross at 1-866-227-2184 to determine whether a treatment is considered Experimental or Investigative.

Hospice

▪ "Hospice" means a facility that is engaged in providing palliative care rather than curative care to terminally ill individuals. The Hospice must be certified by Medicare to provide hospice services or accredited as a Hospice by the appropriate regulatory agency, and appropriately licensed in the state where it is located.

Hospital

▪ A "hospital" is a short-term, acute care facility that has been approved by the Joint Commission on Accreditation of Healthcare Organizations and/or by the American Osteopathic Hospital Association or by Blue Cross/Blue Shield and that:

- Is a duly licensed institution
- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians
- Has organized departments of medicine
- Provides 24-hour nursing service by or under the supervision of registered nurses
- Is **not**, other than incidentally, a:
  - Skilled nursing facility
  - Nursing or custodial care home
  - Health resort, spa, or sanitarium
  - Place for rest or for the aged
  - Place for treatment of mental illness, or alcohol or drug abuse
  - Place for provision of rehabilitation care
  - Place for treatment of pulmonary tuberculosis
  - Place for provision of Hospice care

In-network

▪ "In-network" refers to the health care providers who are part of the Preferred Provider Organization (PPO).

Independent Clinical Laboratory

▪ "Independent clinical laboratory" means a laboratory that performs clinical pathology procedures and that is not affiliated or associated with a Hospital, Physician, or Facility Provider.

Inpatient Admission

▪ "Inpatient admission" (or "inpatient") means your actual entry into a Hospital, extended care facility, or Facility Provider to receive inpatient services as a registered bed patient in such hospital, extended care facility, or Facility Provider and for whom a room and board charge is made. The Inpatient Admission shall continue until such time as you are actually discharged from the facility.

Medically Necessary/Medically Appropriate

▪ "Medically necessary" or "medically appropriate" means services or supplies provided by a Facility Provider that Blue Cross/Blue Shield determines are:

- Ordered by a Professional Provider or other appropriately licensed health care professional
- Required for the diagnosis or direct care and treatment of your condition, illness, disease, or injury
- Appropriate for the symptoms and diagnosis of your condition, illness, disease, or injury
- In accordance with standards of good medical practice as generally recognized and accepted by the medical community
- Not primarily for your immediate family's convenience, or the convenience of the Facility Provider or Professional Provider
- The most efficient and economical supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as a bed patient due to the nature of the services rendered for your condition, and you cannot receive safe and adequate care in some other setting without adversely affecting your condition or quality of medical care.
- "Medically necessary" or "medically appropriate" means services or supplies provided by a Professional Provider that Blue Cross/Blue Shield determines are:

- Appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease, or injury
- Provided for the diagnosis, or the direct care and treatment of your condition, illness, disease, or injury
- In accordance with current standards of good medical practice
- Not primarily for your convenience, or the convenience of your Professional Provider
- The most efficient and economical supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as a bed patient due to the nature of the services rendered for your condition, and you cannot receive safe and adequate care in some other setting without adversely affecting your condition or quality of medical care
- Medically necessary care does not include experimental or investigative services.

- When you use providers who do not have an agreement with Blue Cross/Blue Shield ("non-participating" providers), you may be billed for services or treatment that is not medically necessary or appropriate, as determined by Blue Cross/Blue Shield. You can avoid these charges by using "participating" Blue Cross/Blue Shield providers. (See below for details on participating and non-participating providers.)

- The care you actually receive should depend on the decisions you and your doctor reach about medical necessity. The decision to seek medical treatment or any health care service is solely yours. You should not judge your need for care solely on the criteria of medical necessity as judged by Independence Blue Cross or the Patient Care Management Program.

Out-of-Network

- "Out-of-network" refers to health care providers who are not part of the PPO network of participating providers.

Out-of-Network, Out-of-Pocket Maximum

- "Out-of-network, out-of-pocket maximum" is the specified dollar amount you will have to pay out of your own pocket for out-of-network covered services in a calendar year. Deductible and penalty amounts do not accumulate toward your out-of-network, out-of-pocket maximum.

Participating/Non-Participating Provider

- If you receive services from a health care provider outside the PPO network (i.e., a non-network provider), you need to understand the difference between "participating" and "non-participating" health care providers.

- Participating Providers have entered into an agreement with Blue Cross and Blue Shield pertaining to payment of benefits for covered services. These providers agree to accept the Blue Cross and Blue Shield plan allowance as payment-in-full for covered services. You will be responsible for any deductibles, coinsurance amounts, copays, or amounts exceeding plan maximums. The sum of your payment and the plan's payment will be accepted as payment in full.

- Non-Participating Providers have not entered into an agreement with Blue Cross and Blue Shield pertaining to payment of benefits and, therefore, may bill you for the difference between the provider's actual charge and the plan allowance. This amount may be significant.

  - Non-Participating Facility Providers—For services rendered by hospitals and other facility providers, the allowance may not refer to the actual amount paid to the provider by Independence Blue Cross (IBC). Under its contracts with hospitals and other facilities, IBC pays using bulk purchasing arrangements that save money at the end of the year but do not produce a uniform discount for each individual claim. Therefore, the amount paid by IBC at the time of any given claim may be more or less than the amount used to calculate your liability.

  - Non-Participating Professional Providers—Payment for covered services performed by a non-participating professional provider, such as a physician, will be made based on the amount the plan would have paid to an in-network provider for the same service. This payment will constitute full discharge of Blue Cross and Blue Shield's liability under the program.

▪ Non-Participating Providers are not obligated to accept the plan allowance as payment in full. Therefore, you will be responsible for paying any remaining charges.

Physician

- "Physician" means a person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) and who is licensed and legally entitled to practice medicine in all its branches, including performing surgery and dispensing drugs.

Preferred Provider Organization (PPO)

- "A Preferred Provider Organization" is a type of managed care plan that offers the freedom to choose a physician like a traditional health care plan, and provides the physician visits and preventive benefits normally associated with an HMO (Health Maintenance Organization). In a PPO, an individual is not required to select a primary care physician to coordinate care and is not required to obtain referrals to see specialists.

- Doctors and hospitals that have agreed to participate in the PPO network treat PPO members for a discounted cost.

Skilled Nursing Facility

- "Skilled nursing facility" means an institution or a distinct part of an institution, that is:

- Accredited as a Skilled Nursing Facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations; or

- Certified as a Skilled Nursing Facility or extended care facility under the Medicare Law; or

- Otherwise acceptable to Blue Cross/Blue Shield.

- The term "Skilled Nursing Facility" does not include any institution or part of an institution that is used primarily for the care and treatment of alcohol or drug abuse, mental illness, or tuberculosis.

Surgery

- "Surgery" means the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations, and other invasive procedures. Payment for Surgery includes an allowance for related Inpatient pre-operative and post-operative care. Treatment of burns, fractures, and dislocations are also considered surgery.

Other Benefits

Vision Care Plan Highlights

- The Fund administers a vision care plan. Here are some key features of the plan.

Eligibility	You may be eligible if your employer is making contributions to the Welfare Fund as the result of a collective bargaining agreement.
Eligible Dependents	Your eligible dependents include your spouse and unmarried children under age 19 (under age 23 if full time student at an accredited educational institution) who depend on you for their support.
When Your Coverage Begins	After your employer has made the minimum required contribution in a month, you will be eligible to participate in the corresponding benefit period beginning on the first day of the second month after the contribution is due.
Cost	Your employer makes contributions to the Welfare Fund on your behalf.
How the Plan Works	You may see any vision care provider of your choice. The Fund reimburses up to $300 per covered person every 24 months for an exam, lenses, frames, and contact lenses.
Claim Submission	You must bring a claim form with you to your exam. Claim forms are available from the Fund office.
When Your Coverage Ends	You will no longer be eligible to participate in the vision plan if your employer contributions to the Welfare Fund on your behalf fall below the minimum required amount.
Questions	Call the Fund office at 1-215-542-8211.

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The Vision Care Plan

What the Fund Pays

- The Fund pays up to $300 for you and $300 for each covered family member every 24 months for an exam, lenses, frames, and contact lenses.

How to Use the Plan

- You may see any vision care provider of your choice. To use the plan, call the Fund office for a claim form. Bring the claim form with you. You may receive a complete eye examination/fitting from any qualified optician, opthalmologist, or optometrist. You may purchase lenses, frames, and contact lenses.

- You pay for the cost of the eye exam, lenses, frames, and contact lenses at the time of service. Then, send the claim form to the Fund office for reimbursement.

Covered Vision Expenses

- The vision care plan covers the following expenses:

- Eye examination and refraction to determine your prescription
- Standard lenses:
  - Single vision lenses
  - Bifocal lenses
  - Trifocal lenses
  - Aphakic/lenticular
  - Progressive
- Specialty lenses (including but not limited to polycarbonates and High index)
- Frames
- Contact lens evaluation and fitting
- Contact lenses:
  - Disposable
  - Standard (including but not limited to hard/soft daily wear spherical, bifocal, toric, gas permeable)

Vision Expenses Not Covered

- The vision care plan does not cover the following expenses:

- Special procedures
- Medical or surgical treatment of the eyes
- Services or materials provided as a result of workers' compensation law or obtained by any governmental agency or program
- Non-prescription glasses

Filing Vision Claims

- You must pay the full cost of the eye exam, lenses, frames, and contact lenses up front. The Fund will reimburse you up to $300 per covered person every 24 months, but not to exceed the actual charges incurred.

- Claim forms are available from the Fund office.

- To file a claim, have your vision care provider complete the claim form. Then, send the completed claim form and the original provider bill to the Fund office. The bill should include:

- The provider name and address
- Date of service
- Patient name
- Type of service and charges
- The member's name and Social Security number
- Send claims to:

  - IUOE Welfare Fund
  P.O. Box 1627
  Fort Washington, PA 19034

- You should file claims within **90** days of incurring the expense. In any case, all vision claims must be filed no later than one year following the date you incur an eligible charge. Claims received after that time will not be considered for payment.

- Your claim will be processed as soon as administratively possible.

If Your Claim Is Denied

- The vision care plan has a specific claims review procedure for appealing denied claims. Generally, you must appeal a denial of benefits within 180 days. Special procedures apply for urgent and pre-service health care claims.

- See the **Plan Operation and Rights** section for details on how to appeal a denied claim.

If You Have Vision Benefits under Another Plan

- If you have vision benefits under a plan other than the Welfare Fund's, you may not submit a claim to the Fund for care paid by the other plan.

Laser Eye Surgery Plan Highlights

- The Fund administers a laser eye surgery plan. Here are some key features of the plan.

Eligibility	You may be eligible if your employer is making contributions to the Welfare Fund as the result of a collective bargaining agreement.
Eligible Dependents	This is a member-only benefit. Dependents are not eligible for this benefit.
When Your Coverage Begins	After your employer has made the minimum required contribution in a month, you will be eligible to participate in the corresponding benefit period beginning on the first day of the second month after the contribution is due.
Cost	Your employer makes contributions to the Welfare Fund on your behalf.
How the Plan Works	You may see any provider of your choice. The Fund reimburses 80% of the cost of the procedure, up to a maximum charge of $1,500 per eye once per lifetime.
Claim Submission	You must file a claim for reimbursement. Claim forms are available from the Fund office.
When Your Coverage Ends	You will no longer be eligible to participate in the laser eye surgery plan if your employer contributions to the Welfare Fund on your behalf fall below the minimum required amount.
Questions	Call the Fund office at 1-215-542-8211.

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The Laser Eye Surgery Plan

What the Fund Pays

- The Fund pays 80% of the cost of the surgery, up to a maximum charge of $1,500 per eye once per lifetime.

- The maximum charge is the maximum amount the Fund recognizes for laser eye surgery. Your benefit amount will be determined based on the maximum charge—that is, the coverage percentage will be applied to the maximum charge- or the actual amount, whichever is less.

- Example

- If you receive laser eye surgery and the surgery costs $2,000 per eye, your costs could look like the following:

▪ Provider's Charge	▪ $2,000 per eye
▪ Per Lifetime Maximum Charge	▪ $1,500 per eye
▪ Fund Payment	▪ $1,500 X 80% = $1,200 per eye
▪ Your Cost	▪ $2,000 - $1,200 = $800 per eye

How to Use the Plan

- You may see any qualified provider of your choice. You pay for the cost of the surgery at the time of service. Then, you file a claim for reimbursement with the Fund office.

Filing Laser Eye Surgery Claims

- Claim forms are available from the Fund office.

- To file a claim, have your provider complete the claim form. Then, send the completed claim form and the original provider bill to the Fund office. The bill should include:

- The provider name and address
- Date of service
- Type of service and charges
- The member's name and Social Security number
- Send claims to:

  - IUOE Welfare Fund
  P.O. Box 1627
  Fort Washington, PA 19034

- You should file claims within **90** days of incurring the expense. In any case, all laser eye surgery claims must be filed no later than one year following the date you incur an eligible charge. Claims received after that time will not be considered for payment.

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Hearing Aid Plan Highlights

- The Fund administers a hearing aid plan. Here are some key features of the plan.

Eligibility	You may be eligible if your employer is making contributions to the Welfare Fund as the result of a collective bargaining agreement.
Eligible Dependents	This is a member-only benefit. Dependents are not eligible for this benefit.
When Your Coverage Begins	After your employer has made the minimum required contribution in a month, you will be eligible to participate in the corresponding benefit period beginning on the first day of the second month after the contribution is due.
Cost	Your employer makes contributions to the Welfare Fund on your behalf.
How the Plan Works	The Fund reimburses 100% of the cost of a hearing aid, up to a maximum $1,000 payment per device (maximum of 4 devices per lifetime).
Claim Submission	You must file a claim for reimbursement. Claim forms are available from the Fund office.
When Your Coverage Ends	You will no longer be eligible to participate in the hearing aid plan if your employer contributions to the Welfare Fund on your behalf fall below the minimum required amount.
Questions	Call the Fund office at 1-215-542-8211.

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The Hearing Aid Plan

What the Fund Pays

- The Fund pays 100% of the cost of the hearing aid, up to a $1,000 payment per device.

Lifetime Maximum

- The Fund covers a maximum of four devices per lifetime.

How to Use the Plan

- You pay for the cost of the hearing aid at the time of service. Then, you file a claim for reimbursement with the Fund office.

Filing Hearing Aid Claims

- Claim forms are available from the Fund office.

- To file a claim, have your provider complete the claim form. Then, send the completed claim form and the original provider bill to the Fund office. The bill should include:

- The provider name and address
- Date of service
- Type of service and charges
- The member's name and Social Security number
- Send claims to:

  - IUOE Welfare Fund
  P.O. Box 1627
  Fort Washington, PA 19034

- You should file claims within **90 days** of incurring the expense. In any case, all hearing aid claims must be filed no later than one year following the date you incur an eligible charge. Claims received after that time will not be considered for payment.

- Your claim will be processed as soon as administratively possible.

If Your Claim Is Denied

- The hearing aid plan has a specific claims review procedure for appealing denied claims. Generally, you must appeal a denial of benefits within 180 days. Special procedures apply for urgent and pre-service health care claims.

- See the **Plan Operation and Rights** section for details on how to appeal a denied claim.

Dental

Dental Plan Highlights

- The Fund's dental plan is administered by *Fidelio.* Here are some key features of the dental plan.

Eligibility	You may be eligible if your employer is making contributions to the Welfare Fund as the result of a collective bargaining agreement.
Eligible Dependents	Your eligible dependents include your spouse and unmarried children under age 19 (under age 23 if full time student at an accredited educational institution) who depend on you for their support.
When Your Coverage Begins	After your employer has made the minimum required contribution in a month, you will be eligible to participate in the corresponding benefit period beginning on the first day of the second month after the contribution is due.
Cost	Your employer makes contributions to the Welfare Fund on your behalf.
Dental Plan	The Fund offers a dental Preferred Provider Organization (PPO) administered by *Fidelio* Insurance Company.
How the Plan Works	You may see any dental provider of your choice. However, if you use a dentist who participates in the *Fidelio* network of providers (called a participating dentist), you'll save money—there is no deductible to meet for basic and preventive services; you pay a lower coinsurance for major services; and there are no surprise bills afterward because participating providers accept the contracted payment amount as payment in full.
Claim Submission	Your dental provider will file claims for you. Covered family members will need to bring the member's Social Security number with them to their appointment.
When Your Coverage Ends	You will no longer be eligible to participate in the dental plan if your employer contributions to the Welfare Fund on your behalf fall below the minimum required amount.
Questions	▪ For questions about benefits and participating dental providers, call 1-800-262-4949 or visit www.fideliodental.com. ▪ For questions about eligibility, call the Fund office at 1-215-542-8211.

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Preferred Provider Organization (PPO) Dental Plan

- Regular, professional dental care is not only essential for good health, but it also can prevent serious or costly problems later on. That's why the Welfare Fund offers you a dental Preferred Provider Organization (PPO) plan administered by *Fidelio* Insurance Company.

How the PPO Dental Plan Works

- The dental PPO gives you the option to receive care from a participating dentist or any other dental provider. However, if you use a participating dentist, you'll save money.

- **Participating Dentists**—Participating dentists are dentists in the *Fidelio* network of providers who have negotiated a fee schedule with *Fidelio* and have agreed to accept this set fee, or "maximum allowable charge," as payment in full—so you won't get any surprise bills. Your share of the cost will be a percentage of this discounted maximum allowable charge. There is no deductible when you use a participating dentist for preventive or basic services. (You pay any amounts exceeding your yearly maximum benefit.)

- For dental care provided by a participating dentist, *Fidelio* pays 100% for preventive and diagnostic care, 100% for basic and restorative services, and 65% after the deductible for major services, up to a maximum benefit of $1,000 per person per calendar year. In addition, *Fidelio* pays 80% (no deductible) for orthodontia services for children under age 19 with a lifetime maximum benefit of $1,000.

- **Non-Participating Dentists**—When you use non-participating dentists (dentists who are not in the *Fidelio* PPO network), dental benefits are based on the usual, customary, and reasonable (UCR) amount, so it's possible that you will incur an extra out-of-pocket expense. If your dentist charges more than the UCR amount, you are responsible for the difference.

- After a $25 per person or $75 per family annual deductible, *Fidelio* pays 100% of UCR for preventive and diagnostic care, 80% of UCR for basic and restorative care, and 50% of UCR for major care. There is a $1,000 per person per calendar year annual maximum benefit for all preventive and diagnostic, basic and restorative, and major services. In addition, *Fidelio* pays 50% (no deductible) for orthodontia services for children under age 19 with a lifetime maximum benefit of $1,000.

Choosing a Participating Dentist

- You may visit any participating dentist and receive the negotiated fee—you are not required to choose one dentist from the list. When you make an appointment with your dentist, you should identify yourself as a *Fidelio* dental PPO member and reconfirm that the dentist is a *Fidelio* participating provider. There are no special ID cards or claim forms to use.

- To find a participating dentist or to see if your current provider is in the *Fidelio* network, visit www.fideliodental.com. Or, you may call 1-215-885-2443 or 1-800-262-4949 during normal business hours. You may also call the *Fidelio* Hotline seven days a week, 24 hours a day at 1-215-885-2453 or 1-800-929-0340. You will need the member's Social Security number.

Eligible Dental Expenses

- An "eligible dental expense" is one that a dentist makes for preventive and diagnostic, basic and restorative, and major services, or orthodontic services, furnished to you or a covered dependent, provided the service is:

- On the list of covered services
- Not covered under your medical plan
- Not excluded
- "Incurred" while you are covered by the plan

- A charge will be considered "incurred" on the date:

- An impression is taken for dentures or bridges or other appliances or modifications of an appliance
- A tooth is prepared for a crown or restoration
- A pulp chamber is opened for root canal therapy
- Any other service is actually received

Sharing the Cost of Services

- While the dental plan pays a major portion of your dental care expenses, you also pay a portion. Your share depends on whether you receive care from a participating or non-participating dentist.

Deductible

- The deductible is the amount of eligible expenses that you must pay each calendar year before the plan starts paying benefits. A combination of in- and out-of-network services is used to satisfy the deductible. When you use a participating dentist, you do not need to meet the deductible before the plan pays for preventive and basic services.

- You must meet the individual deductible for all other services before the plan pays benefits. If you have family coverage, you must meet the family deductible. The eligible expenses of all covered family members are combined to meet the family deductible. However, no one person may contribute more than the individual deductible amount towards the family deductible.

- You must meet the deductible before the plan pays benefits (except for preventive and basic services at a participating dentist). Your individual deductible is $25. The family deductible is up to $75. For example, if you have family coverage and 3 **or more** members of the family use the dental benefit you will pay the full $75 family deductible, assuming charges are at least $75. If only 2 family members use the benefit you will pay $50.

- Expenses that are not covered by the plan, including charges in excess of UCR amounts, do not count toward your annual deductible.

Coinsurance

- Coinsurance is the percentage of eligible expenses paid for certain services.

- **For dental care provided by a participating dentist**—*Fidelio* pays 100% for preventive and diagnostic care, 100% for basic services, and 65% after the annual deductible for major services. In addition, *Fidelio* pays 80% (no deductible) for orthodontia services for children under age 19.

- **For dental care provided by a non-participating dentist**—*Fidelio* pays 100% of UCR for preventive and diagnostic care after the annual deductible, 80% of UCR after the annual deductible for

basic and restorative services, and 50% of UCR after the annual deductible for major services. In addition, *Fidelio* pays 50% of UCR (no deductible) for orthodontia services for children under age 19.

Usual, Customary, and Reasonable (UCR)

- The usual, customary, and reasonable (UCR) charge is the amount that the Fund considers a fair or typical charge for the service in your area. If you use providers who do not accept the UCR amount, you will have to pay the amount over the UCR amount. This difference does not count toward the annual deductible.

Maximum Benefit

- *Fidelio* will pay up to $1,000 per person per calendar year for eligible dental expenses. This maximum is applied to the combination of in- and out-of-network services received.

Lifetime Maximum Orthodontia Benefit

- *Fidelio* will pay up to a maximum lifetime benefit of $1,000 per eligible dependent child under age 19 for eligible orthodontia services. This maximum is applied to the combination of in- and out-of-network services received and is separate from the $1,000 per person per calendar year maximum benefit.

Snapshot of Dental Benefits

- This chart is a summary of the benefits provided under the *Fidelio* PPO dental plan.

Features	Participating Dentist	Non-Participating Dentist*
Calendar Year Deductible	$25 per person/up to $75 per family (does not apply for basic and preventive services at a participating dentist)	
Calendar Year Maximum	$1,000 per person	
Lifetime Orthodontia Maximum	$1,000 per eligible dependent child under age 19	
Usual, Customary, and Reasonable (UCR) Charges	The plan covers only UCR charges if you do not use a *Fidelio* participating dentist.	
Preventive and Diagnostic Care		
▪ Oral exams (2 X each calendar year) ▪ Cleaning (2 X each calendar year) ▪ Fluoride treatments under age 19 (1 X each 12 months) ▪ Sealants for children under age 14 ▪ Space maintainers ▪ Full-mouth x-rays (1 X every 3 years) ▪ Bitewing x-rays (1 X each 12 months) ▪ Lab tests	100%, no deductible	100% of UCR after deductible
Basic and Restorative Services		
▪ Fillings ▪ Emergency Treatment for pain	100%, no deductible	80% of UCR after deductible
Major Services		
▪ Gum disease treatment (periodontia) ▪ Oral surgery (extractions) ▪ General anesthetics ▪ Repairing crowns, inlays, bridgework, or dentures ▪ Rebasing or relining dentures or adding teeth to fixed bridgework or partial dentures (limits apply) ▪ Root canal (endodontia) ▪ Full or partial dentures or fixed bridgework ▪ Crowns and gold fillings (limits apply)	65% after deductible	50% of UCR after deductible
Orthodontia Services		
Orthodontia for children under age 19	80%, no deductible	50% of UCR, no deductible

**Benefits are based on the usual, customary, and reasonable (UCR) amount. If the actual charge is more than UCR, you will have to pay the difference, and these amounts will not count toward your annual deductible.*

Alternative Forms of Treatment

- There is often more than one satisfactory way to treat certain dental conditions. For example, the dentist could use an amalgam filling or replace the tooth with a more expensive crown or gold filling. The plan will base its benefits on the least expensive appropriate treatment that meets acceptable dental standards. If you choose a more expensive treatment option, you pay the difference in cost.

Pre-determination of Plan Payments

- If your treatment is expected to cost $250 or more, your dental provider must "predetermine benefits" with *Fidelio* before the treatment starts (this means evaluating whether the suggested treatment is appropriate and determining how much the plan will pay for the care).

- Your dentist simply needs to send a claim form to *Fidelio* detailing the treatment plan. The estimated charges and x-rays should be included.

- After *Fidelio* has processed the Request for Predetermination, a copy is mailed to the dentist and you showing the estimated benefits payable. You can review the treatment plan with the dentist and agree on the services to be performed.

- After treatment is completed, your dentist should return the original form (indicating any changes in the treatment plan) to *Fidelio* for payment.

- With predetermination, you know exactly how much the plan will pay—and how much you will pay. That way, you can make financial arrangements in advance before the final course of treatment begins.

Covered Dental Services

- The dental plan covers the following preventive and diagnostic care, as well as basic and restorative and major services.

Preventive and Diagnostic Care

- The dental plan will pay 100% of eligible charges with no deductible for care received at a participating dentist and 100% of UCR after the deductible for care received at a non-participating dentist for the following services:

- Oral examinations, once every six months
- Cleaning of teeth (prophylaxis), once every six months
- Fluoride treatment for children age 18 or younger, once every 12 months
- Sealants for children age 13 or younger
- Space maintainers
- Full-mouth x-rays, once every three years
- Bitewing and other x-rays taken as part of a general examination, once every 12 months
- Lab tests

Basic and Restorative Care

- The dental plan pays 100% of eligible charges (no deductible) when you use a participating dentist and 80% of UCR after the deductible when you use a non-participating dentist for the following services:

- Amalgam, silicate, acrylic, synthetic porcelain, and composite fillings

- Emergency treatment for relief of dental pain even if no actual dental treatment is provided at that visit. If treatment is provided, benefits will be based upon the appropriate covered treatment

Major Care

- The dental plan pays 65% of eligible charges after the deductible when you use a participating dentist and 50% of UCR after the deductible when you use a non-participating dentist for the following services:

- Necessary periodontic treatment of the gums and supporting structure of the teeth
- Oral surgery (extractions)
- General anesthesia is covered when medically necessary for complex surgical procedures and in conjunction with covered oral surgery, extractions, or other covered dental service. (Extractions of fully or partially bony impacted wisdom teeth are covered by the medical plan)
- Repairing or recementing of crowns, inlays, dentures, or bridgework
- Relining and rebasing of existing removable full or partial dentures (after six months of original placement) or adding teeth (no time or number of teeth limitations) to partial dentures
- Root canals and other endodontic treatment
- The initial placement of fixed bridgework or full or partial dentures
- Crowns and gold fillings once every five years
- Replacement of bridges or dentures if the existing denture or bridgework can no longer be used and was installed at least five years prior to its replacement
- Adding teeth to an existing full or partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed

Orthodontic Care

- Orthodontia benefits cover the detection, prevention, and correction of abnormalities in the positioning of teeth in their relationship to the jaw.

- Children age 18 or younger are eligible for orthodontic benefits, as long as they remain eligible for coverage.

- The dental plan pays 80% of the eligible orthodontic charges with no deductible when you use a participating orthodontist and 50% of UCR with no deductible when you use a non-participating orthodontist for the following services:

- Initial diagnostic procedures
- Removal of teeth
- Correction of malocclusion by wire appliances, braces, and other mechanical aids

File a Predetermination for Orthodontic Treatment

- To make sure your orthodontic care is covered, you should file a predetermination of benefits with *Fidelio*. A Predetermination for Orthodontic Treatment shows the recommended treatment plan with the estimated charges and supporting x-rays and study models.

- After *Fidelio* has processed the Request for Predetermination, a copy is mailed to the dentist and you showing the estimated benefits payable.

How Orthodontic Benefits Are Paid

- *Fidelio* uses the treatment plan and approved predetermination to determine the plan's benefits.

- If treatment is expected to last less than two years, the benefit is divided into equal installments. Payments are made at nominal six-month intervals over the estimated course of treatment, beginning with the date the appliance is installed. If treatment is expected to continue for two or more years, the benefit will be paid in five installments, at equal-time intervals.

- Benefits will be paid until the lifetime maximum is reached or insurance terminates, if sooner.

Maximum Orthodontic Benefit

- Each enrolled child age 18 or younger can receive a separate lifetime maximum benefit of $1,000 for orthodontic services. This benefit is in addition to the dental plan $1,000 annual maximum for preventive and diagnostic, basic and restorative, and major services.

Dental Expenses Not Covered

- The following expenses are not covered under the dental plan:

- Charges incurred before the effective date of coverage
- Charges for treatment by someone other than a dentist, physician, or dental technician under the supervision of a dentist or physician
- Services and supplies that are cosmetic in nature
- Replacement of a lost, missing, or stolen crown, bridge, or denture
- Repair or replacement of an orthodontic appliance
- Services and supplies for an injury or sickness which happens during work at any job for pay or profit, or sickness for which payment is made or is available through workers' compensation or a similar law
- Services or supplies covered by an employer's liability law
- Expenses that you are not legally required to pay or for which no charge would be made in the absence of dental benefits
- Services or supplies deemed experimental in nature in terms of generally accepted dental standards
- Services or supplies needed as a result of war, or a warlike act in time of peace
- Any duplicate appliance or prosthetic device
- Training or supplies used to educate people on the care of their teeth
- Periodontal splinting
- Charges for treatment of bruxism (grinding of teeth) or other myofunctional therapy for the correction of harmful habits
- Charges for implants
- Charges for the replacement of teeth missing before you became covered under the plan, and expenses incurred as the result of impressions taken before the effective date of coverage
- Charges for broken appointments
- Charges by the dentist for completing dental forms
- Sterilization supplies
- Dental services that have been covered as medical expenses
- Treatment in a U.S. government or agency hospital
- Services and supplies furnished by a family member
- Bleaching of teeth

Filing Dental Claims

- Typically, your dentist will file claims for you. Your dentist may use a standard reimbursement form developed by the American Dental Association. You and your eligible dependents must provide the member's Social Security number to your dentist on the day of your appointment.

- Claims should be mailed to:

- ***Fidelio* Dental Insurance**
2826 Mt. Carmel Avenue
Glenside, PA 19038

- Remember that you must ask your dentist to send a claim form to "pre-determine benefits" if your expenses are expected to exceed $250.

Coordination of Benefits

- See Coordination of Benefits in the **Other Important Information** section if you are covered by more than one group plan (for example, as an IUOE Local 542 member and as your spouse's dependent under another employer plan).

If Your Claim Is Denied

- The dental plan has a specific claims review procedure for appealing denied dental claims. Generally, you must appeal a denial of benefits within 180 days. Special procedures apply for urgent and pre-service health care claims.

- See the **Plan Operation and Rights** section for details on how to appeal a denied claim.

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Prescription Drug

Prescription Drug Plan Highlights

- The Fund's prescription drug plan is administered by Express Scripts (ESI). Here are some key features of the plan.

Eligibility	You may be eligible if your employer is making contributions to the Welfare Fund as the result of a collective bargaining agreement.
Eligible Dependents	Your eligible dependents include your spouse and unmarried children under age 19 (under age 23 if full time student at an accredited educational institution) who depend on you for their support.
When Your Coverage Begins	After your employer has made the minimum required contribution in a month, you will be eligible to participate in the corresponding benefit period beginning on the first day of the second month after the contribution is due.
Cost	Your employer makes contributions to the Welfare Fund on your behalf.
Prescription Drug Plan	The prescription drug plan is provided through Express Scripts. Three-tiered plan—You pay $10 for generic, $20 for preferred (formulary) brand, and $40 for non-preferred (non-formulary) brand at retail pharmacy. Mail order is two times the retail copay.
Claim Submission	Claim submission is generally not required when you use a participating pharmacy or mail order. When you use a non-participating pharmacy or if you do not use your prescription drug card at a participating pharmacy, you must file claim forms.
When Your Coverage Ends	You will no longer be eligible to participate in the prescription drug plan if your employer contributions to the Welfare Fund on your behalf fall below the minimum required amount.
Questions	▪ For questions about benefits, participating pharmacies, mail order, and the plan's preferred drug list (formulary), call 1-800-467-2006 or visit www.express-scripts.com. ▪ For questions about eligibility, call the Fund office at 1-215-542-8211.

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The Prescription Drug Plan

Member Service Center

- A Member Service Center representative can answer questions about finding a participating pharmacist, obtaining the plan's preferred drug list, providing you with mail order information, or refilling your mail order prescription.

- To reach an Express Scripts Member Service Center representative, call 1-800-467-2006, or visit their Web site at www.express-scripts.com. You will need the member's social security number in order to access information.

Prescription Drug Card

- After you are enrolled in the Express Scripts prescription drug plan, you will receive a prescription drug card. Be sure to keep your prescription drug card with you—you will need it when you fill your prescriptions at a participating retail pharmacy. The prescription drug card also contains phone numbers and other important information about your coverage.

Filling a Prescription

- The prescription drug plan administered through Express Scripts offers two ways to fill your prescriptions: at retail pharmacies or by mail order.

Retail Pharmacies

- When you need to fill a prescription, simply take your prescription and Express Scripts prescription drug card to a participating Express Scripts retail pharmacy. The plan will pay 100% of the cost to fill your prescription after you pay your applicable copay or coinsurance.

- **If you use a non-participating pharmacy or fail to use your card, you will pay a higher share of the cost. See details specific to your plan on the following pages.**

- Retail prescriptions are limited to a 34-day supply. If you need more than two refills, you must use the mail-order program or benefits will not be provided.

- More than 53,000 pharmacies, including national chains and independent retailers, participate in the Express Scripts network. To find a participating pharmacy near you, call the toll-free number on your prescription drug card or log on to www.express-scripts.com.

Mail Order-Exclusive Home Delivery

- Mail order is ideal for today's busy lifestyle. Medications are delivered to your door. And, you save on trips to the pharmacy for refills. You can receive up to a 100-day supply, which means you won't need to worry about refills for three months.

- The plan will pay 100% of the cost to fill your prescription after you pay your applicable copay or coinsurance. See Page 57 for information about your additional cost if you use a brand name drug that has a generic equivalent.

- For the first prescription for a maintenance medication (prescription drugs that you are expected to take for six months or more), you may obtain a one-month supply plus two refills from a participating retail pharmacy. After that, the Fund will cover the medication only if you order it through the Exclusive Home Delivery program from the Express Scripts mail-order pharmacy.

- Maintenance medications are medications you take on an ongoing basis to treat and maintain a chronic condition such as:

• Anemia	• Emphysema	• High blood pressure
• Arthritis	• Epilepsy	• Thyroid or adrenal conditions
• Diabetes	• Heart disorders	• Ulcers

To Use Mail Order-Exclusive Home Delivery

- For your first mail order prescription, ask your doctor for two prescriptions—one for the initial prescription that you can fill at a participating retail pharmacy and one for the mail-order program. Your doctor can prescribe up to a 100-day supply of eligible "maintenance drugs" and up to three refills for mail order.

- Then, you need to complete the mail order form (available in your welcome packet or by going to www.express-scripts.com) and mail the form, the prescription, and a check, money order, or credit card number for your copay to the mail order pharmacy provided through Express Scripts.

- Your order will be processed and mailed to your home within 14 days, along with reorder instructions for future prescriptions and/or refills.

- For refill orders, you may do one of the following:

- Use the refill order form included with your prescription
- Log on to www.express-scripts.com
- Call the toll-free number on your prescription drug card

- To access mail order and have your prescriptions delivered to your home, call the toll-free number on your prescription drug card or visit the Express Scripts Web site at www.express-scripts.com.

- Shipping is free. However, you will be charged for overnight or second-day delivery when you request such service.

About the Preferred Drug List (Formulary)

- A formulary is a list of brand name drugs that are included on the plan's preferred drug list. An Express Scripts medical committee of pharmacists and physicians selects the drugs to be included on the preferred drug list. The drugs included in the formulary are chosen because of their safety, effectiveness, and affordability. The formulary may be updated from time to time.

- If your doctor prescribes a drug that is not on the preferred drug list, you will pay more, so ask your doctor if another drug that is on the list can be used to treat your condition.

- If your doctor does not have a copy of the formulary, you may want to provide him or her with a copy and ask to have it kept with your medical files. Your doctor will make prescribing decisions for your medical treatment, but this list provides your doctor with choices.

- A copy of the plan's list of "preferred" drugs (or formulary) was sent with your prescription drug card. You may also call the toll-free number on your card and request a copy. Or, you may access the formulary on the Express Scripts Web site at www.express-scripts.com.

Generic Versus Brand Name: What's the Difference?

- When a company manufactures a new drug, it obtains a patent that lasts 20 or more years. This patent gives the company the exclusive and legal right to manufacture and market the drug during the life of the patent. These "brand name" drugs are expensive to develop, test, get Food and Drug Administration (FDA) approval for, and promote once approved. All of these expenses are included in the retail cost of the drug, making it expensive.

- A generic drug can be produced once the brand name drug patent has expired. The FDA must also approve all generic drugs before they can be sold. To gain approval, generic drugs must contain the same active ingredients and meet the same FDA standards for quality, strength, and purity as their brand name counterparts—but they cost much less.

- The only significant difference between a brand name drug and a generic equivalent is the price. In fact, brand name drugs can cost as much as 90% more than the generic form.

The Three-Tiered Prescription Drug Plan

- Your prescription benefits vary depending on whether the drug is generic, preferred brand name, or non-preferred brand name.

- A preferred brand name drug is a prescription drug that is manufactured and marketed under a trademark or name by a specific drug manufacturer and is included on the plan's preferred drug list (or "formulary").

- A non-preferred brand name drug is a prescription drug that is manufactured and marketed under a trademark or name by a specific drug manufacturer that is not included on the plan's preferred drug list.

Your Pharmacy and Mail Order Copays

Prescription Drug Category	Pharmacy	Mail Order
Generic	$10 copay for up to a 34-day supply	$20 copay for up to a 100-day supply
Preferred brand name	$20 copay for up to a 34-day supply	$40 copay for up to a 100-day supply
Non-preferred brand name	$40 copay for up to a 34-day supply	$80 copay for up to a 100-day supply

If you Use a Brand Name Drug That Has a Generic Equivalent

- **Important:** If you use a brand name drug (preferred or non-preferred) that has a generic equivalent, you pay the copay for the brand name drug (as shown in the chart above), plus the difference between the cost of the brand name drug and the cost of the generic equivalent drug.

If You Use a Non-Participating Pharmacy or Fail to Use Your Card

- You must pay 20% of the average wholesale price of a drug for:

- Prescriptions filled at a pharmacy that does not participate in the Express Scripts network

- Prescriptions filled at a participating pharmacy when you do not use your Express Scripts prescription drug card

- You must pay for the prescription and file a claim for reimbursement from Express Scripts. The plan will reimburse you 80% of the average wholesale price of the drug less any applicable copay.

Covered Prescription Drugs

- The prescription drug plan covers medications, products, or devices that have been approved by the Food and Drug Administration and which can, under state law, be dispensed only by prescription. Drugs covered under the plan include:

- Federal legend drugs
- State-restricted drugs
- Compounded medications
- Insulin and syringes
- Injectables
  - The three-tiered plan covers physician-directed chemotherapy and insulin treatments at the applicable copay. You must pay a 20% coinsurance ($20 minimum) for all other injectables
- Oral contraceptives for female members and spouses of members

Prescription Drug Charges Not Covered

- Some prescription drugs and supplies are not covered under the plan. The plan does not cover:

- Over the counter (OTC) drugs, vitamins, diet supplements, and other items that may be prescribed by a physician but can be purchased without a prescription
- Prescription drugs when there is an over the counter (OTC) equivalent
- Oral contraceptives or drugs that may be used to prevent pregnancy, unless used for another purpose, for dependents other than your spouse
- Contraceptive devices for dependents other than your spouse
- Fertility drugs
- Artificial appliances, therapeutic devices, or similar devices
- Drugs prescribed by anyone other than a licensed physician
- Prescriptions dispensed by anyone other than a licensed pharmacist
- Drugs administered to any patients of any hospital
- Drugs that do not meet federal or state law requirements for a prescription for that diagnosis
- Drugs that do not, by federal or state law, require a prescription
- Drugs otherwise provided for under any government program, law, workers' compensation, or occupational disease laws
- Prescriptions that you try to refill too soon
- Any other exclusions as outlined in the **Medical** section of this SPD

Filing Prescription Drug Claims

At a Participating Pharmacy

- **If you have your prescription filled at a pharmacy that participates in the Express Scripts network, you do not need to file claims**. You simply need to bring your prescription drug card with you when you have your prescription filled. Keep in mind, you will be responsible for your copay or coinsurance at the time of purchase.

At a Non-Participating Pharmacy or Without Your Card

- **You will need to file a claim if you:**

- Have your prescription filled at a pharmacy that does not participate in the Express Scripts network
- Do not show your prescription drug card at a participating pharmacy
- You must pay the total cost of the prescription at the pharmacy. The Fund will reimburse you:
- 80% of the average wholesale price of the drug less any applicable copay

  Note: If you order a brand name drug that has a generic equivalent, the amount that the Fund reimburses you will be reduced by the difference between the cost of the brand name drug and the cost of the generic drug.

- To file a claim, follow the instructions on your Express Scripts prescription drug card. Send the original receipt to Express Scripts. The receipt should include:

- The pharmacy name and address
- Date of service
- Patient name
- Member name and Social Security number
- Name of drug
- Cost of drug

- You should try to file claims within **90** days of incurring the expense. In any case, all prescription drug claims must be filed no later than 180 days following the date you incur an eligible charge. Claims received after that time will not be considered for payment.

- Your claim will be processed by Express Scripts soon as administratively possible.

If Your Claim Is Denied

- The prescription drug plan has a specific claims review procedure for appealing denied claims. Generally, you must appeal a denial of benefits within 180 days. Special procedures apply for urgent and pre-service health care claims.

- See the **Plan Operation and Rights** section for details on how to appeal a denied claim

EAP and Mental Health and Substance Abuse

Employee Assistance Program (EAP) and Mental Health and Substance Abuse Highlights

- Here are some key features of the EAP and your mental health and substance abuse benefits provided through Preferential Care Network (PCN).

Eligibility	You may be eligible if your employer is making contributions to the Welfare Fund as the result of a collective bargaining agreement.
Eligible Dependents	Your eligible dependents include your spouse and unmarried children under age 19 (under age 23 if full time student at an accredited educational institution) who depend on you for their support.
When Your Coverage Begins	After your employer has made the minimum required contribution in a month, you will be eligible to participate in the corresponding benefit period beginning on the first day of the second month after the contribution is due.
Cost	Your employer makes contributions to the Welfare Fund on your behalf.
How the EAP Works	The EAP provides short-term counseling over the phone, 24 hours a day, seven days a week. When you call, a professional counselor will work with you to assess your situation. If necessary, they will schedule a face-to-face visit with a trained mental health professional. The Fund pays the full cost for up to three visits with a counselor each calendar year.
How Mental Health and Substance Abuse Benefits Work	PCN provides you with inpatient and outpatient mental health and substance abuse services. You may see any provider of your choice. However, if you use a provider or facility that participates in PCN's network of providers, you'll save money. If you don't have a provider, PCN can help you find one. Before you begin treatment, whether you use a participating provider or not, you must call PCN to pre-certify treatment or benefits will not be paid.
Claim Submission	Your PCN provider will file claims for you. Covered family members will need to bring the member's Social Security number with them to their appointment. If you go to an out-of-network provider, you must file claims.
When Your Coverage Ends	You will no longer be eligible to participate in the EAP and Mental Health and Substance Abuse plans if your employer contributions to the Welfare Fund on your behalf fall below the minimum required amount.
Questions	▪ For questions about benefits and participating providers, call 1-800-366-0129. ▪ For questions about eligibility, call the Fund office at 1-215-542-8211.

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Employee Assistance Program (EAP)

- The employee assistance program (EAP) is a counseling, information, and referral service that helps you address personal problems on a confidential basis. Benefits are provided through Preferential Care Network (PCN).

- If you and your dependents are eligible for Welfare Fund benefits, you may take advantage of the EAP. You do not need to enroll; coverage is automatic.

How the EAP Works

- The EAP provides short-term counseling over the phone 24 hours a day, seven days a week. When you call, a professional counselor will take as much time as you need and will work with you to assess the situation.

- If necessary, they will schedule a face-to-face visit with a trained mental health professional. The Fund pays the full cost for up to three visits with a counselor each calendar year. These sessions are intended to prevent life's problems from turning into serious difficulties by helping you clarify the problem, identify your options, and develop a plan of action to achieve your goals. When appropriate, PCN can refer you to additional resources outside the EAP.

- To reach the EAP, call 1-800-366-0129.
Help is available 24 hours a day, 365 days a year.

PCN Counselors and Confidentiality

- PCN counselors include licensed psychologists, licensed clinical social workers, and licensed marriage and family counselors. All counselors are trained specialists.

- Your call to the EAP is confidential—all records are treated confidentially. No information can be released outside of the EAP without your written consent, and no one at the Fund office will have access to information about your personal circumstances.

- All calls to the EAP are confidential. No information can be released without your written consent.

Available Services Through the EAP

▪ The EAP provides up to three face-to-face sessions per calendar year with a qualified PCN participating provider for a wide range of personal issues and concerns. Call PCN any time of the day or night when you need help with such issues as:

Personal	Work	Family
▪ Alcohol or drug abuse	▪ Attendance	▪ Marital
▪ Physical health	▪ Performance	▪ Separation or divorce
▪ Mental health	▪ Retirement	▪ School problems
▪ Health issues	▪ Conflicts	▪ Domestic violence
▪ Sexual issues	▪ Sexual harassment	▪ Caring for an elderly parent
▪ Relationship problems	▪ Downsizing issues	
▪ Stress		
▪ Depression		▪

Trauma or Critical Incidents

▪ Critical incidents such as gruesome deaths, hostage situations, natural disasters, and suicides can sometimes create added stress. The stress from these events has the potential to significantly influence your behavior and emotional well-being. If you are involved in such an incident, PCN offers Critical Incident Stress Debriefing and Counseling.

Mental Health and Substance Abuse Benefits

- In addition to your employee assistance program (EAP) benefit, inpatient and outpatient mental health and substance abuse services are also provided through PCN. If you've accessed EAP and further treatment is needed, PCN will review your mental health and/or substance abuse needs to confirm that the requested care is necessary.

How PCN Works

- PCN provides care through a carefully selected network of mental health care providers and facilities that have agreed to accept negotiated fees as payment in full for their services. When you need care, you select a provider of your choice. The provider can be in the PCN network (called "in-network") or out of the network (called "out-of-network"). Generally, your out-of-pocket costs are lower when you use an in-network provider.

You Must Pre-Certify All Treatment

- The Fund requires pre-certification of all treatment, which ensures that you receive quality care while preventing unnecessary treatment.

- **You Must Pre-Certify All Care**

All treatment of mental health disorders and substance abuse, including all in- and out-of-network services, must be pre-certified through PCN or benefits will not be paid. To pre-certify treatment, call 1-800-366-0129 any time of the day or night.

- You must call PCN before you receive treatment. If you do not, benefits will not be paid.

If You Receive Treatment after Pre-Certification Is Denied

- If you decide to receive treatment after review and written notification that treatment is not considered medically necessary, or if you receive treatment without pre-certifying care, benefits will not be provided. You will be financially liable for non-covered charges.

How to Access Care

- To receive mental health and substance abuse benefits, call PCN to pre-certify your treatment. PCN will determine the level of care that is needed and, if you don't already have one, will assist you in finding a provider. PCN will continue to review your case during the course of treatment, monitoring your progress and recommending a change to another level of care, as appropriate.

Choosing a Provider

Choice of In-Network Providers

- PCN maintains a database of information on each in-network provider. If you have any questions regarding any in-network providers or facilities, you can call PCN 24 hours a day, seven days a week, or you can call the provider directly.

- To find an in-network provider near you, call PCN at 1-800-366-0129 any time of the day or night.

Changing Providers

- When you call PCN, they will make every attempt to select an in-network provider who will best meet your needs. If you are dissatisfied with the in-network provider you've seen, call PCN at 1-800-366-0129. After discussing your needs and preferences, they may locate another provider for you.

Out-of-Network Providers

- If you already have a provider who is not in the network, you may continue to see that provider. However, you must pre-certify treatment. Your benefits will be lower when you use out-of-network providers.

Sharing the Cost of Services

- While the program pays most of the expenses, you also pay a portion. Your share depends on whether you received in- or out-of-network care.

Deductible

- The deductible applies to out-of-network, outpatient care and is the amount of expenses per person that you must pay each calendar year before the program starts paying benefits.

- You must meet the deductible for out-of-network, outpatient care before the program pays benefits for those services. Your annual deductible is $300 per person.

Usual, Customary, and Reasonable (UCR)

- The usual, customary, and reasonable (UCR) amount is the amount that the Fund considers a fair or typical charge for the service in your area. If you use providers who do not accept the UCR amount, you will have to pay the amount over UCR. This difference does not count toward the annual deductible.

What the Program Pays

- You may use providers in the PCN network or any other qualified provider. The program pays a larger share of your expenses when you receive care from PCN-affiliated service professionals.

Treatment	In-Network Care	Out-of-Network Care*
Outpatient	100%	100% of UCR after the deductible
Inpatient	100%	100% of UCR

**When you receive out-of-network care, benefits are based on UCR. The program pays 100% of either the actual charge or the UCR amount, whichever is lower. You pay the difference.*

It's Confidential

- All calls to PCN are confidential. No information can be released outside of PCN without your written consent. Your bills, if any, will not be sent to the Fund office. Instead, all information concerning these confidential areas will go directly to PCN for processing.

Filing Claims

In-Network Claims

- **If you use an in-network provider, you do not file claims**. PCN providers file in-network claims on your behalf. You simply need to bring the member's Social Security number with you when you go to the doctor or hospital, and show it when you check in.

- You may be asked to fill out a member information form when you are there. Once you supply the necessary information, your doctor or hospital takes care of filing the claim directly.

Out-of-Network Claims

- **If you go to an out-of-network provider, you may need to file your own claim**. This is because these doctors and hospitals are not set up to file claims with your network directly. However, some out-of-network providers may submit the claim directly and then bill you for any deductible or expense that is due.

- When you go to the doctor or hospital, you should bring the member's Social Security number with you. In some cases, you may have to pay first for the expense and then file your claim for reimbursement.

- Claim forms are available from the Fund office.

- To file a claim, have your provider complete the claim form. Then, send the completed claim form and the original provider bill to the Fund office. The bill should include:

- The provider name and address
- Date of service
- Patient name
- Type of service and charges
- Diagnosis
- The member's name and Social Security number
- Send claims to:

- PCN
3 Neshaminy Interplex
Suite 207
Trevose, PA 19053

- 1-800-366-0129

- If you have already paid the bill, include proof of payment so that any payment will be made to you.

- You should try to file claims within **90** days of incurring the expense. In any case, all health care claims must be filed no later than one year following the date you incur an eligible charge. Claims received after that time will not be considered for payment.

- Your claim will be processed by PCN as soon as administratively possible.

Coordination of Benefits

- See Coordination of Benefits in the **Other Important Information** section if you are covered by more than one group plan (for example, as an IUOE Local 542 member and as your spouse's dependent under another employer plan).

If Your Claim Is Denied

- The Fund has a specific claims review procedure for appealing denied claims. Generally, you must appeal a denial of benefits within 180 days. Special procedures apply for urgent and pre-service health care claims.

- See the **Plan Operation and Rights** section for details on how to appeal a denied claim.

Weekly Disability

Weekly Disability Highlights

- Here are some key features of the weekly disability benefits provided through the Fund.

Eligibility	You may be eligible if your employer is making contributions to the Welfare Fund as the result of a collective bargaining agreement.
Eligible Dependents	This is a member-only benefit. Dependents are not eligible for this benefit.
When Your Coverage Begins	After your employer has made the minimum required contribution in a month, you will be eligible to participate in the corresponding benefit period beginning on the first day of the second month after the contribution is due.
Cost	Your employer makes contributions to the Welfare Fund on your behalf.
Weekly Disability Benefit	The Fund administers the weekly disability benefit, which may be used for absences of a few days if an illness or injury prevents you from working or for extended periods of disability. You must be under the care of an M.D. or D.O. in the continental United States.
When Benefits Begin	Your weekly disability benefits will begin on the following: ▪ First day of disability due to an off-the-job accident ▪ First day if hospitalized ▪ Eighth day after you first come under the professional care of your M.D. or D.O. for an illness
How Long Benefits Are Paid	You may receive weekly disability benefits for up to 39 weeks for: ▪ Any one period of disability, or ▪ All disabilities during any 52-consecutive-week period
Benefit Amount	Weekly disability provides you with up to $250 per week for a non-work related illness or injury that prevents you from working.
Claim Submission	You must call the Fund office to start your disability claim process.
When Your Coverage Ends	You will no longer be eligible to participate in the disability plan if your employer contributions to the Welfare Fund on your behalf fall below the minimum required amount.
Workers' Compensation	If your illness or injury is work-related, you must apply for workers' compensation through your employer. You would not be eligible for weekly disability benefits.
Questions	Call the Fund office at 1-215-542-8211.

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Weekly Disability Benefits

- Knowing you have a steady source of income if you become disabled and can't work is important to your financial security and peace of mind. That's why the Welfare Fund offers this valuable benefit.

When Weekly Disability Benefits Begin

- Weekly disability benefits may be used for absences of a few days or for extended periods of disability. Your disability must begin while you are eligible for this benefit.

- Benefits will begin on the following:

- First day of disability due to an off-the-job accident
- First day if hospitalized
- Eighth day after you first come under the professional care of an M.D. or D.O. for an illness

Definition of Disability

- To receive benefits you must be totally disabled and under the professional care and regular attendance of an M.D. or D. O. within the continental limits of the United States. Totally disabled means you are unable to perform the duties required by your job.

Amount of Benefits

- Weekly disability benefits can provide you with $250 per week (or $35.72 per day if your disability lasts less than a week).

About Taxes

- FICA is withheld for the first 6 months. Nothing is withheld after you've been on weekly disability for 6 months.

How Long Benefits Continue

- As long as you remain disabled, you may receive weekly disability benefits for up to 39 weeks for:

- Any one period of disability
- All disabilities during any 52-consecutive-week period

What You Need to Do

- If you are disabled due to a non-work related injury or illness, call the Fund office to start the claim process.

- Your disability must be certified by an M.D. or D.O. within the United States. If the sickness or injury is work-related, you must apply for workers' compensation benefits through your employer instead.

When Weekly Disability Benefits Renew

- Generally, weekly disability benefits are renewed 52 weeks from your initial claim date. The initial claim date is determined from the date you are first seen and treated by an M.D. or D.O.

- You must return to full-time, active work for at least 80 hours between the first and second 52-week periods in order for your weekly disability benefits to be renewed.

Example

- If you file a claim in February, you would become eligible for another 39 weeks the following February, as long as you return to work for at least 80 hours before February 1 and you meet other eligibility criteria.

If You Return to Work and Become Disabled Again

- If you recover from the disability, return to full-time, active work for less than 80 hours, and become disabled again, benefits for the second period of disability will be considered as a continuation of the first period.

When Disability Benefits Are Not Paid

- Weekly disability benefits will not be paid:
- For illness or injury incurred that is work-related or covered by workers' compensation or other occupational disease laws
- For illness or injury that is not certified by an M.D. or D.O. within the United States
- For a period during which you are collecting unemployment benefits
- If you become disabled during a period when you are not eligible for a weekly disability benefit from the Fund

Filing Claims

- Call the Fund office at 1-215-542-8211 to start the claim process.
- The Fund will send you an Employee Claim Form for Injury Or Illness. You must:
- Complete and sign the form that you are sent
- Ask your doctor to complete and sign the Attending Physician's Statement on the other side of your claim form. If your doctor is not sure when you will return to work, ask the doctor to estimate this date
- Send the form to the Fund office
- With each check, you will receive a certification form to sign and return, verifying that you are still disabled. Once a month, your attending physician must complete and return a form; it must be a **new** form completed and signed by the physician, not by you.

If Your Claim Is Denied

- The Fund has a specific claims review procedure for appealing denied claims. Generally, you must appeal a denial of benefits within 180 days.
- See the **Plan Operation and Rights** section for details on how to appeal a denied claim.
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Death and Accident

Death and Accident Benefits Highlights

- Here are some key features of the death and the accidental death and dismemberment benefits provided through the Fund.

Eligibility	You may be eligible if you are working for an employer who is making contributions to the Welfare Fund as the result of a collective bargaining agreement.	
When Your Coverage Begins	After your employer has made the minimum required contribution in a month, you will be eligible to participate in the corresponding benefit period beginning on the first day of the second month after the contribution is due.	
Cost	Your employer makes contributions to the Welfare Fund on your behalf.	
Beneficiary	You elect a beneficiary by completing a beneficiary form.	
	Death Benefit	**Accidental Death and Dismemberment Benefits**
When Benefits Are Paid	A benefit may be paid to your beneficiary if you were eligible for: ▪ Welfare benefits in 6 of the 12 months immediately preceding your death; and ▪ Welfare Fund benefits on the day you died	A benefit may be paid to your beneficiary if you were eligible for death benefits coverage on the day you died and your death is deemed accidental. A benefit may be paid to you if you are seriously injured in a covered accident provided you were eligible for death benefits on the day of your accident.
Benefit Amount	The death benefit provides your beneficiary with a benefit equal to $5,000 minus the death benefit payable by the IUOE Local 542 Pension Fund.	If your death is deemed accidental, the accidental death benefit provides your beneficiary with a benefit equal to $5,000 minus the accidental death benefit payable by the IUOE Local 542 Pension Fund. If you are seriously injured in a covered accident, you may receive $5,000 or $10,000, minus the dismemberment benefit payable by the IUOE Local 542 Pension Fund, depending on the bodily losses you incur. See the **Accidental Dismemberment Benefits** schedule on Page W-75.
Claim Submission	Your beneficiary should notify the Fund office.	You or your beneficiary should notify the Fund office.
When Your Coverage Ends	You will no longer be eligible for these benefits if your employer contributions to the Welfare Fund on your behalf fall below the minimum required amount.	
Questions	Call the Fund office at 1-215-542-8211.	

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Death Benefits

Benefit Amount

- Your beneficiary may receive a death benefit equal to $5,000 minus the death benefit payable by the IUOE Local 542 Pension Fund.

When Benefits Are Paid

- If you die, a benefit may be paid to your beneficiary. Your beneficiary will receive a benefit if:
- You are eligible for Welfare benefits in six out of the 12 months immediately preceding your death; and
- You are eligible for Welfare benefits on the day you die

Naming Your Beneficiary

- You elect a beneficiary by completing a Beneficiary Designation Form. You may name anyone as your beneficiary. You are not required to name your spouse as beneficiary of the $5,000 death benefit if you are married, although you may name your spouse. If you name more than one beneficiary, you may specify different amounts to be paid to each. If you do not specify different amounts, your beneficiaries will receive equal shares.

- You can change your beneficiary at any time by completing a new Beneficiary Designation Form and filing it with the Fund office.

- If you do not name a beneficiary, or if your beneficiary dies before you, benefits will be paid to your survivors in the following order:

- Your spouse
- Your children
- Your parents
- Your brothers and sisters
- Your estate
- Payments will be made in equal shares if there is more than one beneficiary.

- We cannot release information regarding your beneficiary designation to anyone but you or your documented Power of Attorney (POA) while you are alive and to anyone but the beneficiary or the attorney representing the estate once you are deceased.

Accidental Death and Dismemberment Benefits

- Accidental death and dismemberment benefits provide coverage for you against two types of loss—accidental death and accidental bodily injury.

Benefit Amount

- **Your beneficiary may receive an accidental death benefit** equal to $5,000 minus the accidental death benefit payable by the IUOE Local 542 Pension Fund.

- **You may receive accidental dismemberment benefits** according to the schedule below if you are seriously injured in a covered accident.

Accidental Dismemberment Benefits	
For loss of…	**You receive…**
Both hands, both feet, the sight of both eyes, or any combination	$10,000 minus the accidental dismemberment benefit payable by the IUOE Local 542 Pension Fund
One hand, one foot, or the sight of one eye	$5,000 minus the accidental dismemberment benefit payable by the IUOE Local 542 Pension Fund

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- Loss of a hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight means total and permanent loss of sight.

When Benefits Are Paid

- Accidental death benefits will be paid to your beneficiary if your death is deemed accidental, as indicated on the death certificate, and occurs within 120 days after the date of a covered accident. A covered accident is one not included in the exclusions listed below.

- Accidental dismemberment benefits will be paid to you if your loss is deemed accidental and occurs within 120 days after the date of a covered accident.

- "Accidental" means caused by external, violent, and accidental means. In the case of accidental death, it is as determined by the death certificate submitted and subject to the Plan's exclusions.

Naming a Beneficiary

- Your accidental death benefit is paid to the same beneficiary as your death benefit. The accidental dismemberment benefit is paid directly to you.

Accidents Not Covered

- The following are not considered accidental:
- Disease or illness of any kind, including mental illness
- Medical or surgical treatment, including diagnostic procedures
- Suicide or intentional self-inflicted injury
- Asphyxiation by gas inhalation, bacterial infection, or taking of poison
- War or service in the Armed Forces
- While committing an assault or felony
- The operation of, or riding in, aircraft, except as a passenger on a regularly scheduled airline flight
- Occupational death
- Acts of terrorism
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Filing Claims

- If you die, your beneficiary should notify the Fund office promptly. The Fund office will send your beneficiary a Death Claim Form. Your beneficiary should send:
- Completed and signed Death Claim Form. If there is more than one beneficiary, every beneficiary should sign the form and include their name, address, date of birth, and Social Security number
- Certified copy of your official death certificate

▪ The beneficiary in the case of your accidental death will be the same beneficiary you designate for your death benefits.

- If you lose your sight or a limb, you must notify the Fund office within 30 days after the injury occurs. You will need to provide:
- Certified proof of the date and circumstance of the accident that resulted in dismemberment
- A completed claim form

If Your Claim Is Denied

- The Fund has a specific claims review procedure for appealing denied claims. Generally, you (or your beneficiary) must appeal a denial of benefits within 180 days.
- See the **Plan Operation and Rights** section for details on how to appeal a denied claim.

Other Important Information

Coordination of Benefits

- Sometimes individuals are covered by more than one group plan (for example, as an IUOE Local 542 member and as your spouse's dependent under another employer's plan). If both plans paid their full benefits, the total benefits paid for one claim could be more than the actual expense—and that would increase the cost of health care for everyone. That is why the IUOE Local 542 Welfare Fund has a coordination of benefits (COB) provision.

- The plan works with other health care plans to reimburse up to 100% of allowable health care expenses for you or your dependents. To obtain all the benefits for which you are eligible, you must submit claims to each source of coverage.

How Benefits Are Determined

- If the Welfare Fund is primary, then your benefits will be paid as usual, without regard to the other plan. The coordination of benefits rules of the other plan will determine the benefits paid by the other plan.

- If the Welfare Fund is the secondary payer (i.e., the other plan is responsible for paying benefits first, and the Fund pays second), it determines its normal benefit, and then subtracts the benefit you receive from the primary payer:

Welfare Fund Plan Benefit
Minus
Other Plan Benefit
Equals
Welfare Fund Plan Benefit Paid

- If the Welfare Fund would normally pay more than the other plan, you can receive the difference. If the normal benefit from the Welfare Fund is less than, or the same as, the other plan's benefit, you will not receive any benefit from the Welfare Fund.

- Remember, the secondary plan pays benefits only after the primary plan pays, or denies, the claim. You must submit information showing how much the primary plan considered and paid.

Which Plan Pays First

- When there are two sources of coverage, one of the plans is considered primary and pays its usual benefits first. Then the other plan (called the secondary plan) may pay benefits depending on the provisions of its plan.

- The following rules determine which plan pays benefits first:

- If the other plan does not have a coordination of benefits provision, that plan pays first and this plan is secondary.

- The plan that covers the patient directly will pay benefits before the plan that covers the person as a dependent.

- For children who are dependents under both plans, the plan of the parent whose birthday (month and day) occurs earlier in the calendar year pays first. If both parents have the same birthday, then the plan that covered the parent longer pays first.

- If the other plan does not have the birthday rule, the other plan will determine the order of benefits.

- If a covered dependent child's parents are legally separated or divorced, the primary plan is determined in the following order:

  - The plan of the parent whom a court has ordered to have financial responsibility for health care expenses pays first (if the insurance carrier has also been notified).

- If no court order exists, the plan of the parent with custody of the child pays first.

- If a court order establishing order of payment has been made, the plan will pay claims in accordance with the order as soon as administratively possible.

- The plan that covers the person as an active employee will pay benefits before the plan that covers the person who is inactive due to layoff or retirement, or covers the person as a dependent.

- If none of the rules above apply, the plan that has covered the patient for the longest time pays first.

- The plan will coordinate with any type of group coverage. Group coverage means coverage made available by a trustee, union, or association, or an employer other than your employer or the Fund, or coverage provided under a governmental program or provided by statute (other than Medicare or Medicaid).

- Group coverage includes pre-payment plans such as a Health Maintenance Organization (HMO), group association coverage for an employee or dependent made available by an employer, or student coverage obtained through an educational institution above the high school level. The coordination provision does not apply to any individual policy you may have.

- Expenses that will be coordinated with this plan include any necessary, usual, and prevailing expense that is covered, at least in part, by this plan. This plan will not coordinate with or reimburse for charges that were refused by another plan as the result of non-compliance with utilization management or cost containment provisions.

Subrogation of Benefits

- Upon receipt of a claim for benefits wherein any possible third party liability exists, the Welfare Fund shall have the right to be subrogated by written agreement between the Employee or Dependent and the Welfare Fund. To the extent of any such benefits paid, it shall be the duty of the member to furnish the Welfare Fund with all pertinent information for the purpose of complying with this provision.

- The purpose of this provision is to insure that the limited funds available to finance the benefits provided by the Plan are not used to provide benefits where other Available Funds may be available to pay the cost of the benefits provided by the Fund.

For the purposes of this subsection the following definitions shall apply:

(1) The term “Participant” shall mean any participant in the Plan, together with any dependent and/or beneficiary who may be entitled to benefits under the terms of the Plan.

(2) The term “Illness or Injury” shall mean any illness or injury of whatever kind or description, whether arising out of a work related cause or whether unrelated to the work of the Participant.

(3) The term “Available Funds” shall mean monies and/or compensation from any source whatsoever (whether called pain and suffering, weekly indemnity, workers’ compensation, damages, restitution, out-of-pocket expenses, or any like or similar terms).

(4) The terms “Claim” or “Third Party Claim” shall mean any claim for monetary or non-monetary compensation of whatever kind or description whether made by petition (e.g. workers’ compensation petition), court complaint, insurance claim or written or oral demand.

As a condition to the receipt of benefits from the Plan each Participant shall agree that in the event that the Plan has made, does make or is obligated to make payments to or on behalf of the Participant arising out of any Illness or Injury then, as a condition for receiving benefits from the Plan, the Participant shall execute an agreement providing that the Participant will:

(1) Notify the Plan in writing that a Claim relating to such Illness or Injury has been filed by the Participant against a third party seeking Available Funds.
(2) Notify the Plan in writing of the name and address of the Participant's attorney, provide said attorney with a copy of the agreement and require said attorney to comply with its terms. The agreement shall serve as authorization to the Participant's attorney to comply with its terms and to release all requested information about the Claim(s) to the Plan.
(3) Keep the Plan informed in writing of the progress and/or settlement of his/her Third Party Claim.
(4) Include in all Claims a claim for benefits paid by the Plan to and/or claimed from the Plan by the Participant, plus interest accruing from the date of payment of such benefits.
(5) Reimburse the Plan in full for any benefits paid by the Plan to or on behalf of such benefits.
(6) Require and authorize his/her attorney, if any, to withhold from Available Funds any monies due the Plan pursuant to the agreement and to forward them to the Plan as required by the agreement. In case of any dispute over what monies are due the Plan, Available Funds are to be escrowed pending resolution of such dispute.

In the event that the Participant fails or refuses to comply with the provisions of the Plan, in the provisions of the plan and the agreement, then the Plan, in addition to any other rights which the Plan or the Trustees thereof might have, shall have the right to withhold from any payments due or which become due to the Participant or to third parties on behalf of the Participant any amount necessary until the Plan is fully reimbursed.

The Participant shall authorize the Plan to record and/or use the agreement in any proceedings involving the Participant, including using the agreement in any Third Party Claims that the Participant may have.

The Participant shall authorize any person or entity paying Available Funds to or on behalf of the Participant to pay over to the Plan such monies as the Plan is entitled to receive under the terms of the Plan and the agreement, and the agreement shall constitute their warrant to do so. In case of any dispute over what monies are due the Plan, Available Funds shall be escrowed pending resolution of such dispute.

Any Participant making a Claim on behalf of any minor child under the plan of benefits and who shall make the agreement on behalf of said minor child shall warrant that he/she is authorized to make the agreement on behalf of said minor child.

It is agreed that any payment received by the Participant from any health insurance carrier, from Blue Cross, from Blue Shield, or from any health plan, for which the Participant has paid the full premium in order to secure individual, as distinguished from group, coverage shall be excluded from the requirements of this provision.

Assignment of Benefits

- You or your covered dependents may not transfer ownership of Fund benefits to anyone else. However, benefit payments will be made directly to your health care provider in appropriate circumstances.

Termination of Benefits Upon Misuse

- If your or your dependent(s) willfully misuse any benefits or misrepresent your own or a dependent's eligibility, you could lose coverage for Fund benefits and you will have to repay the Fund for the full amount of any benefits improperly received. The Plan Administrator has responsibility for investigating the misuse of any benefits. If the Plan Administrator believes benefits have been misused or improperly received you will be notified of the reason(s). Those reasons include, but are not limited to, the following:

- applying for benefits during any period of time for which you are not eligible
- attempting to claim benefits for persons who do not qualify under the eligibility rules

- submitting claims for benefits for covered health and welfare expenses not actually incurred
- overusing prescription drugs in a manner which is not medically justified
- failing to cooperate with the Fund's investigations

- Based upon your response to this notice and an investigation of the facts, the Plan Administrator may recommend that the Board of Trustees suspend or terminate your coverage. Further, if there is a serious ongoing abuse of benefits, the Plan Administrator may suspend, in whole or in part, your eligibility for benefits pending a determination by the Board of Trustees. Your failure to respond to the Plan Administrator's notice or failure to cooperate with the investigation could lead to a suspension and termination of your benefit coverage. Based on the investigation, the recommendation of the Plan Administrator, and any response from you, the Board of Trustees will determine whether a termination of coverage is appropriate. You will be notified of the Trustees' decision.

- In addition to possible suspension of benefits and termination of coverage under this Fund, anyone who is determined to have intentionally misused benefits shall be:

1. Liable to the Fund for double the costs of the benefits wrongfully received, plus double all other expenses, including reasonable attorneys' fees, incurred by the Fund as a result of the misuse or the recovery of benefits.

2. Subject to appropriate civil prosecution.

- If a member's (or dependent's) claims are paid in error or a claim has been paid based upon false or incomplete information, the Board of Trustees has the authority to request the return of the overpayment or the amount paid as a result of the false or incomplete information previously submitted to the Plan Administrator.

- The Board of Trustees may, in the exercise of its discretion, terminate, suspend, deny or discontinue coverage or benefits, in whole or in part, or may seek to recover any benefit payment to the extent that the Plan Administrator recommends based upon submission of false or incomplete information or to the extent any overpayment has been made.

Workers' Compensation Cases

- With the exception of death benefits, no benefits are payable by the Fund as a result of injury or illness arising out of the course of your employment. This exclusion applies to all work-related injury and/or illness, whether or not incurred in Covered Employment and/or whether or not you have applied for Workers' Compensation benefits. Such illness or injury is compensable through the insurance provided by your employer in accordance with the provisions of Workers' Compensation legislation. This exclusion is not limited or eliminated by any settlement you or your dependent(s) may reach with the Workers' Compensation carrier.

Motor Vehicle Exclusion

- All injuries resulting from motor vehicle accidents and all hospital and medical bills, including prescription drug, pertaining to such injuries are specifically excluded from coverage under the Welfare Plan. Each participant is individually responsible to make their own private arrangements through their automobile insurance company to obtain hospital, medical, and prescription coverage for such injuries. It is recommended that you consult with your automobile insurance agent to make sure that you, your spouse, and your dependents are adequately covered.

- For purposes of this exclusion, motor vehicle means a self-propelled vehicle, operated or designed for use upon public roads.

Right to Examine

- The Fund shall have the right to examine, or cause to be examined, the person of the covered Member/Employee or Dependent, when and as often as it may be reasonably required to confirm any information submitted with respect to a claim for benefits.

Financial Indebtedness

- If it is determined that a Member/ Employee or Dependent is financially indebted to the Fund, the Fund shall, in addition to any and all other legal rights of recovery have the right to apply any benefits payable currently or in the future as a result of claims submitted on behalf of the Member/Employee or any of his Dependents toward the repayment of such indebtedness.

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Plan Operation and Rights

Introduction

- This section covers the administration and funding of the Welfare plans, as well as your rights under three federal laws:

- Employee Retirement Income Security Act of 1974 (ERISA)—governs the funding and administration of benefit plans and your rights to benefits and communications about those plans

- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)—entitles you to continue health care coverage at your expense for a limited time after your coverage or coverage for a dependent ends

- Health Insurance Portability and Accountability Act of 1996 (HIPAA)—mandates your right to privacy with regard to certain health information (called your protected health information), as well as your right to uninterrupted health care coverage if you become covered under another plan by allowing coverage under this plan to count toward satisfying a pre-existing condition of the new plan, providing you meet certain timing requirements

Plan Operation

Plan Name

- International Union of Operating Engineers of Eastern Pennsylvania and Delaware Welfare Plan

Plan Type

- The plans described in this summary plan description (SPD) are Welfare plans.

Plan Sponsor

- The plan sponsor is the Board of Trustees of the International Union of Operating Engineers of Eastern Pennsylvania and Delaware Welfare Fund.

Board of Trustees

- The Trustees shall have the sole and absolute discretion to determine eligibility for welfare benefits and to construe and interpret the plan and the Agreement of Trust, including but not limited to doubtful or disputed terms, and to make factual determinations with respect thereto. Any construction, interpretation, or application of the plan by the Trustees shall be final, conclusive, and binding on all participants and on any person claiming benefits by, through, or on behalf of any participant.

- In addition, the Trustees may delegate any or all of this authority to a claims administrator. To the extent that authority was delegated, the claims administrator has all of the power and authority of the plan administrator.

Union Trustees

- Robert T. Heenan

Thomas Danese
Charles Priscopo
Robert Walsh

- *Mailing Address*
- Suite 100

1375 Virginia Drive
Fort Washington, PA 19034-3257

Employer Trustees

- James Davis

Michael J. Driscoll, Jr.
Walter P. Palmer 3rd

- *Mailing Address*
- c/o Contractors Association of Eastern Pennsylvania

Suite 1105
1500 Walnut Street
Philadelphia, PA 19102-3506

Plan Administrator

- The plan administrator is responsible for the proper administration of the plans according to the terms of the Employee Retirement Income Security Act of 1974 (ERISA) and any documents or contracts.

- The plan administrator is John Heenan.

- *Mailing Address*

- International Union of Operating Engineers of Eastern Pennsylvania and Delaware Welfare Fund

Suite 102
1375 Virginia Drive
Fort Washington, PA 19034-3257
Telephone: (215) 542 8211

Plan Year

- Plan records are maintained on a calendar-year basis, with the last day of the plan year falling on December 31.

Employer Identification Number

- The legal plan documents, any contracts, the summary plan descriptions, and the financial reports are filed with the U.S. Department of Labor (DOL) and the Internal Revenue Service (IRS) under the Employer Identification Number (EIN): 23-1402245.

Plan Documents

- The summary plan description is intended to provide accurate, understandable explanations of the main provisions of the Welfare Fund benefit plans. However, there is no warrant of complete accuracy. For each plan, there is a legal document and/or contract that provides all details. In the event of any discrepancy between a summary plan description and the formal plan document, the plan document will govern. You and your beneficiaries should not rely on an oral description of the plans because the written terms of the plans will always govern. You have a right to review plan documents and related materials as described in **Your Rights as a Participant** later in this section

- Copies of the plan documents, any contracts, and the latest annual report are available for your inspection during normal working business hours from the Fund office.

Employer Contributions

- Employers pay the full cost of the plan. All employer contributions to the Welfare Fund are made in accordance with the employers' collective bargaining agreements with the Union. The collective bargaining agreements require contributions to the Fund at fixed rates.

Balance Billing

- If the employer contributions received on your behalf are less than the required amount for coverage, but paid according to the collective bargaining agreement, you may receive a bill for the difference between the contribution required and the contribution received. This allows you to continue coverage for yourself and your eligible dependents.

- If no employer contributions are due and received, you may be eligible to continue coverage under COBRA (see **COBRA Continuation Coverage** later in this section).

Agent for Service of Legal Process

- If you need to take legal action because of a dispute relating to Welfare Fund benefits, you may contact the Board of Trustees. Legal process may be served on each trustee.

- Legal process also may be served on the plan administrator.

Administrative Information

- The following chart summarizes the funding and administration information for each plan.

Plan or Program Name	Name of Insurer or Administrator of Services	Funding*
Medical ▪ Preferred Provider Organization (PPO) ▪	***Independence Blue Cross*** 1901 Market Street Philadelphia, PA 19103-1400	Benefits are provided through a self-funded program that is financed with employer contributions
Vision ***Laser Eye Surgery***	***Welfare Fund*** Suite 102 1375 Virginia Drive Fort Washington, PA 19034-3257	Benefits are provided through a self-funded program that is financed with employer contributions
Hearing Aid	***Welfare Fund*** Suite 102 1375 Virginia Drive Fort Washington, PA 19034-3257	Benefits are provided through a self-funded program that is financed with employer contributions
Dental Preferred Provider Organization (PPO)	***Fidelio Insurance Company*** 2826 Mt. Carmel Avenue Glenside, PA 19038-2245	Benefits are provided through an insurance contract
Prescription Drug Three-tiered Prescription Drug Plan	***Express Scripts, Inc.*** P.O. Box 390842 Bloomington, MN 55439-0842	Benefits are provided through a self-funded program that is financed with employer contributions
Employee Assistance Program (EAP)/Mental Health and Substance Abuse	***Preferential Care Network (PCN)*** 3 Neshaminy Interplex Suite 207 Trevose, PA 19053-6939	Benefits are provided through an insurance contract
Weekly Disability	***Welfare Fund*** Suite 102 1375 Virginia Drive Fort Washington, PA 19034-3257	Benefits are provided through a self-funded program that is financed with employer contributions
Death and Accident	***Welfare Fund*** Suite 102 1375 Virginia Drive Fort Washington, PA 19034-3257	Benefits are provided through a self-funded program that is financed with employer contributions

** For self-insured plans, the plans are self-insured and unfunded. Current employer contributions pay only current benefit claims and do not fund future benefit claims. Although the claims administrator pays claims under the plans on behalf of the Fund, the claims administrator does not insure or guarantee that claims will be paid. Rather, the claims administrator relies on the Fund to provide it with enough money to pay the claims. The claims administrator cannot pay claims if the Fund does not provide the money.*

For insured plans, the plan's benefits are financed through a group insurance contract. The insurer is responsible for investing the premiums and paying benefit claims. The insurer guarantees the payment of claims incurred before the group insurance contract terminates.

The uninsured Welfare Plans are administered under service agreements with the various carriers and vendors shown in the chart. The administrative services provided pursuant to the contracts include, as applicable: network establishment, maintenance, and management; pre-certification and other utilization review determinations; claims services, in particular claims processing and determination, the initial review of appeals, and payment of benefit claims; and the handling of grievances and various other customer services.

Claims Review Procedures

- You must file claims for benefits under the plan with the applicable claim or plan administrators or insurance companies. The individual plan sections of this summary plan description describe the procedure for filing claims. The procedure for requesting a review of denied claims is described below. As part of the claims administration process, the claim or plan administrators or insurance companies will:

- Pay claims for benefits due under the plan
- Provide written explanations of the reasons for denied claims
- Handle claimant requests for reviews of denied claims
- For insured plans, the final decision on denied claims is made by the insurance company. For self-insured plans, the Board of Trustees makes the final decision on denied claims

- Under the Employee Retirement Income Security Act of 1974 (ERISA), you have the right to appeal a denied claim.

Timing Requirements

- The following timing requirements apply to the claims review and appeal process:

	Urgent Health Claims	Pre-Service Health Claims	Post-Service Health Claims	Disability Claims	All Other Claims
Deadline for Plan Notice of Improper Pre-Service Claim	**24 hours** after receiving an improper claim	**5 days** after receiving an improper claim	N/A	N/A	N/A
Deadline for Plan Notice of Incomplete Claim	**24 hours** after receiving an incomplete claim	N/A	N/A	N/A	N/A
Deadline for Claimant to Complete Urgent Claim	**48 hours** after receiving notice	N/A	N/A	N/A	N/A
Deadline for Plan Notice of Initial Claim Denial Decision	**48 hours** (i) after receiving completed claim or (ii) after the 48-hour claimant deadline, whichever is earlier **72 hours** after receiving the initial claim, if it was proper and complete	**15 days** after receiving the initial claim **30 days** after receiving the claim if the Benefit Program needs more claimant information and if the Benefit Program provides an extension notice during the initial 15-day period	**30 days** after receiving the initial claim **45 days** after receiving the claim if the Benefit Program needs more claimant information and if the Benefit Program provides an extension notice during the initial 30-day period	**45 days** after receiving the initial claim **75 days** after receiving the claim if the Benefit Program needs more information and if the Benefit Program provides an extension notice during the initial 45-day period **105 days** if the Benefit Program needs another extension	**90 days** after receiving the initial claim **180 days** after receiving the claim if the Benefit Program needs an extension for special circumstances and if the Benefit Program provides an extension notice during the initial 90-day period
Deadline for Claimant to Complete Non-Urgent Claim	N/A	**45 days** after receiving the extension notice	**45 days** after receiving the extension notice	**45 days** after receiving the extension notice	N/A
Deadline for Claimant to Appeal Decision	**180 days** after receiving the claim denial	**180 days** after receiving the claim denial	**180 days** after receiving the claim denial	**180 days** after receiving the claim denial	**60 days** after receiving the claim denial
Deadline for Plan Notice of Appeal Decision	**72 hours** after receiving the appeal	**30 days** after receiving the appeal **15 days** after receiving an appeal if the Benefit Program allows two levels of appeal	**60 days** after receiving the appeal **30 days** after receiving an appeal if the Benefit Program allows two levels of appeal	**45 days** after receiving the appeal **90 days** after receiving an appeal if the Benefit Program allows two levels of appeal	**60 days** after receiving the appeal **120 days** after receiving the appeal if the Benefit Program needs an extension

Notice of Denial

- If your claim is wholly or partially denied, the plan or claim administrator will provide a written or electronic notice of this denial. This notice must be provided to you within a reasonable period of time (as described in the Timing Requirements section above) after your claim is received. The written notice must contain the following information:

- The specific reason or reasons for the denial
- Specific reference to the plan provisions on which the denial is based
- A description of any additional information or material necessary to complete your claim and an explanation of why such material or information is necessary
- A description of the plan's review procedures and the time limits for appealing the plan's determination, including an explanation of your right to obtain information about the plan's procedures and to bring a civil action under section 502 of ERISA after a denial of benefits on review
- For medical and disability claims only:
  - if an internal rule or guideline was relied upon in making the denial, either a copy of the specific rule or guideline, or a statement that a copy will be provided free of charge upon request
  - if the denial is based on medical necessity or experimental treatment, either an explanation of the scientific or clinical judgment of the determination applying the terms of the benefit program to your medical circumstances, or a statement that an explanation will be provided free of charge upon request
- For an urgent care claim for medical or dental benefits, a description of the expedited review process; this denial may be given orally, provided that a written or electronic notification is furnished to you no later than 3 days after the oral notification

Appealing a Denied Claim

- If you believe your claim was denied in error, you may appeal this decision to the plan. You have 180 days for most plans (60 days for others) after receiving the claim denial to appeal the plan's decision. You may submit written comments, documents, or other information in support of your appeal and have access, upon request, to all relevant documents free of charge. The review of the claim denial will take into account all new information, whether or not presented or available at the initial claim review, and will not be influenced by the initial claim decision.

- A different person than the one who made the initial claim determination will conduct the appeal review and such person will not work under the original decision maker's authority. If your claim was denied on the grounds of medical judgment, the plan will consult with a health professional with appropriate training and experience. This health care professional will not be the individual who was consulted during the initial determination or work under their authority. If the advice of a medical or vocational expert was obtained by the plan in connection with the denial of your claim, the plan will provide you with the names of each such expert, regardless of whether the advice was relied upon.

- If your claim involves urgent care, a request for an expedited appeal may be submitted orally or in writing and all necessary information shall be transmitted between the plan and you by telephone, fax, or other similar method.

If Your Appeal is Denied

- If your appeal is denied, the denial notice will contain the following information:
- The specific reasons for the appeal determination
- A reference to the specific plan provisions on which the determination was based
- A statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain information about these procedures
- A statement describing your right to bring a civil lawsuit under federal law
- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request)
- If the denial is based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical condition (or state that such information will be provided free of charge upon request)
- A statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."
- The appeal determination notice may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Your Rights as a Participant

- As a participant in the Welfare Fund's benefit program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) as described below.

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, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report

Continue Group Health Plan Coverage

- You are entitled 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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries 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 if, for example, it finds your claim is frivolous.

- You may not bring any legal action to recover under the plan unless you have pursued and exercised all claim and appeal rights within the time limits stated in the plan document and summary plan description, and the requested plan benefits have been denied in whole or in part (or there is any other adverse benefit determination). A claimant who wishes to seek judicial review of a denied appeal must file any civil action within 90 days after the date of the adverse determination on review, or will be forever prohibited from commencing such action.

Assistance with Your Questions

- If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries at the following address:

- Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

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

COBRA Continuation Coverage

- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), a federal law, requires employers who sponsor health care plans to offer a temporary extension of coverage to employees and their eligible dependents. This section generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect your right to receive it.

- COBRA continuation health coverage must be made available in certain instances when health coverage would otherwise end due to a "qualifying event." Specific qualifying events are listed in the chart on the next page. COBRA coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who was covered by the Fund on the day before a qualifying event occurs and who will lose coverage because of a qualifying event. Depending on the type of qualifying event, members, spouses of members, and dependent children of members may be qualified beneficiaries, as shown on the chart.

- Under the plan, qualified beneficiaries who elect COBRA coverage must pay the full cost for this coverage. Generally, individuals covered by the Fund who are also covered by Medicare or by another employer's group health plan on or before the date of the qualifying event may also elect COBRA coverage in the plan.

- Although a former member may elect COBRA coverage for all qualified beneficiaries in the family, each qualified beneficiary (or the individual responsible for a minor or incapacitated individual) has the independent right to elect or decline COBRA coverage for him or herself.

- In addition, a newborn or newly adopted child or a child placed for adoption during the COBRA continuation period may be added to the covered employee's COBRA coverage as a qualified beneficiary within 30 days of birth, adoption, or placement for adoption. The child will only be entitled to coverage for the remainder of the COBRA continuation period from the date of the qualifying event. A new spouse may also be added to the employee's COBRA coverage during the continuation coverage period. However, the new spouse will not be a "qualified beneficiary."

- The rights to COBRA coverage apply separately to you, your spouse, and/or dependent children.

COBRA Qualifying Events

▪ This chart shows the Qualifying Events that may entitle you (or your covered spouse and /or dependent) to COBRA coverage and the length of time coverage may continue.

Qualifying Event	Who May Continue Coverage	Maximum Continuation Period[1]
Member's covered employment stops for any reason (including retirement), except for termination for gross misconduct, or member's hours are reduced resulting in loss of eligibility for the plan	Employee, spouse, dependents Spouse, dependents (only)	Up to 18 months (up to 29 months if disabled at time coverage stopped or within 60 days of continuation)[2] The greater of 36 months from the date employee enrolled in Medicare, or 18 months (29 months if disabled) from employee's date of termination or reduction in hours if the employee is enrolled in Medicare when the loss of coverage occurs
Member divorces or becomes legally separated and spouse's and/or dependent children's coverage ends	Ex-spouse or legally separated spouse, and/or dependent children	Up to 36 months[3]
Member enrolls in Medicare and drops coverage in the Fund's plan	Spouse and dependents	Up to 36 months[3]
Dependent child no longer eligible under plan's terms	Dependent child(ren)	Up to 36 months
Member dies	Spouse and dependents	Up to 36 months

[1] May include period for which the Fund provides the full cost of the benefit.

[2] If a covered family member is disabled (as determined by Social Security) and qualifies for an extension of coverage to up to 29 months, and there are non-disabled family members who are also entitled to COBRA coverage, the non-disabled family members may continue coverage for up to 29 months as well (see Disability Extension later in this section).

[3] If your divorce or legal separation occurs while COBRA coverage is in effect, your covered spouse and children (only) can elect to extend coverage from 18 to 36 months (see Second Qualifying Event Extension later in this section).

Cost of Continuing Coverage

▪ If you or your covered spouse or dependents choose to continue coverage, you will be required to pay the full cost of the coverage plus 2% for administration (102%). If you are disabled at the time you become eligible for COBRA continuation coverage, and you are deemed eligible to extend coverage for up to 29 months, you will be required to pay 150% of the applicable cost after the first 18 months of coverage. But, if only the non-disabled family members elect to continue COBRA coverage under the 11-month disability extension, the cost will remain at 102% (full cost plus 2% for administrative expenses).

How to Apply for COBRA Coverage

▪ The plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of covered employment or reduction of hours of employment, death of the employee, or enrollment of the

employee in Medicare (Part A, Part B, or both, or a Medicare HMO), the employer must notify the plan administrator of the qualifying event within 30 days of any of these events. However, you or your covered spouse or dependent(s) must notify the Fund within 60 days after the following events to be eligible to continue your coverage under the plan:

- Your dependent child stops being eligible for coverage under the plan's terms (e.g., for reasons such as reaching the limiting age)
- You and your spouse legally separate or divorce
- There is a second qualifying event:
  - If your spouse and/or dependents (only) have another qualifying event while already on COBRA due to your employment termination or reduction in hours, they may extend COBRA coverage from 18 (or 29) months to up to 36 months from the date of the employment termination or reduction in hours, due to your divorce, legal separation, or enrollment in Medicare (see Second Qualifying Event Extension below)
  - You or a family member become disabled and qualify for an extension of COBRA coverage (or cease to be disabled and no longer qualify for the disability extension of COBRA coverage) (see Disability Extension below).
- Once your notice has been received, the Fund must in turn notify you, your spouse, and children (individually or jointly) of your right to elect COBRA coverage. You will not need to provide evidence of good health to obtain continuation coverage. If you (or your covered spouse or child) fail to provide the plan administrator with timely notice when one of these qualifying events occurs, the right to COBRA coverage (or if disabled, an extension of COBRA coverage) will be waived. If you have questions about what steps to take or whom to notify, contact the Fund office.

60-day Deadline to Elect COBRA

- To elect COBRA coverage, you (or your covered spouse or children) must submit a completed COBRA application to the Fund office. You will have 60 days from the time coverage stops or the date you receive the application to respond (whichever is later). You and each qualified beneficiary have the right to make an individual election. If you or your dependents do not file your application for COBRA coverage within the time frame mentioned, you will lose the opportunity to continue your coverage.

- For each qualified beneficiary who elects COBRA coverage, COBRA coverage will begin as of the day after the day that plan coverage would otherwise have been lost.

Individuals Eligible for Federal Trade Adjustment Assistance

- Workers whose employment is adversely affected by international trade, such as increased imports or a shift in production to another country, may become eligible for federal trade adjustment assistance (TAA). Part of this assistance is a 65% tax credit toward the purchase of COBRA coverage, if loss of health coverage is trade-related. If you become eligible for TAA after a termination of covered employment or reduction of hours and did not elect COBRA coverage during your initial 60-day election period, you will be eligible for a second COBRA election period.

- This second election period begins on the first day of the month in which you are determined to be a TAA-eligible individual provided this second election is made within 6 months after the date health coverage was originally lost. If you elect COBRA coverage during this second election period, it is effective on the first day of the second election period and not on the date coverage originally was lost.

Adding Dependents after COBRA Begins

- If you are a former member who is covered by COBRA, you may add a new spouse, newborn child, or adopted child to your COBRA coverage, provided you request coverage within 31 days of the marriage, birth, adoption, or placement for adoption, and pay the required premium. Also, under HIPAA, you may add your spouse or eligible dependent who involuntarily loses health coverage under another

employer's group health plan within 31 days of the loss of other coverage, provided you pay the required premium.

Coordination of Benefits and COBRA

- If you have two sources of coverage, one of the plans will be designated as the primary plan (pay benefits first) and the other as the secondary plan (may pay benefits after the primary plan). This is called non-duplication of benefits or coordination of benefits (COB). When you have COBRA coverage, the plan covering the patient as an active employee or a dependent of an active employee will be primary over a COBRA plan. However, the COBRA plan will be primary for benefits that are excluded under an active employee plan's pre-existing condition provision.

Length of COBRA Continuation Coverage

- COBRA coverage is a temporary continuation of health coverage. When the qualifying event is the death of the member, enrollment of the member in Medicare (Part A, Part B or both or a Medicare HMO), your divorce or legal separation, or a dependent child losing eligibility under the plan, COBRA coverage may last for up to 36 months for the covered spouse and dependents (only).

- When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage may last for up to 18 months. There are two ways in which this 18-month period of COBRA coverage can be extended.

Disability Extension

- If you, your covered spouse, or an eligible dependent are totally disabled as determined by the Social Security Administration at the time of your termination of employment or reduction in hours or within 60 days from the date COBRA coverage begins, you and/or all other covered family members may be eligible to extend COBRA continuation coverage beyond the 18-month period, up to a total of 29 months, or the end of the disability if earlier.

- To extend your coverage beyond the 18-month period, you must provide a letter of disability determination to the Fund to show that you are entitled to Social Security disability benefits. You must provide the disability determination letter within 60 days of its receipt and before the end of the 18-month COBRA coverage period.

- If Social Security later determines you or your family member is no longer disabled, you must notify the Fund within 30 days of the date your Social Security disability ended. Your COBRA coverage will then cease effective as of that date, provided you or your covered family members are not otherwise eligible to continue coverage.

Second Qualifying Event Extension

- If your spouse and/or dependents (only) have another qualifying event while already on COBRA coverage due to your covered employment termination or reduction in hours, they may elect to extend COBRA coverage for up to 36 months from the date of the covered employment termination or reduction in hours. For example, assume that you (or your spouse or children) elect COBRA coverage because your employment terminates. If you then enroll in Medicare before the end of the 18-month continuation period, your dependents may continue their coverage for up to 36 months from the date you end your covered employment.

- You (or your spouse or dependent) must notify the Fund within 60 days of a second qualifying event.

- If, after the occurrence of any event described under **COBRA Continuation Coverage** above, you, your spouse, and/or your dependents are allowed to continue health care coverage under the plan (whether or not contributions are required) beyond the plan's termination of coverage provision for any reason other than to comply with the federal law (i.e., the plan's special provisions), such continuation

period(s) will be used to reduce the maximum length of COBRA continuation coverage period otherwise available to such person under this section.

When COBRA Coverage Ends

- After you or your dependents continue coverage in the Welfare plan for the full continuation period allowed, coverage will end. However, COBRA coverage will stop before the maximum continuation period shown in the chart earlier in this section if one of the following events occurs during that period:

- Failure to pay for COBRA coverage on a timely basis. To be considered timely, payment must be received within 30 days after the due date (or 45 days after the due date for the initial payment).

- After you (or your spouse or children) elect COBRA coverage under this plan, you (or your spouse or children) become covered under another group health plan that does not limit coverage for a pre-existing medical condition that you (or they) may have. (However, an individual can be dropped from continuation coverage if he or she becomes covered under a new health care plan and the new plan gives credit for prior coverage that serves to eliminate the pre-existing condition exclusion period.)

- In the case of an individual who was covered under a disability extension, it is determined that the individual is no longer disabled under the Social Security laws.

- An individual who is on duty in the uniformed services fails to apply for, or return to, active employment with their employer.

- A covered individual enrolls in Medicare after electing COBRA coverage.

- Any reasonable grounds for which the plan terminates coverage of an active participant (e.g., such as fraud).

- The Fund discontinues the plan offered to all members.

- No qualified beneficiary who is the employee may continue COBRA coverage for greater than 18 months from the date of the qualifying event (29 months if a qualified disabled person is in the family) and no covered spouse or dependent may continue COBRA coverage for more than 36 months in total for any reason. The total continuation period includes any period of severance in which health care coverage is continued. Once COBRA coverage is cancelled, it will not be reinstated.

General Information

- This section on COBRA continuation coverage does not amend or change the plan's termination of coverage provision. It simply provides a continuation of coverage right the Fund is required to offer by law.

If You Have Questions

- If you have questions about your COBRA continuation coverage, you should contact the Fund office. Or, you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through their website at www.dol.gov/ebsa.

Keep the Fund Informed of Address Changes

- In order to protect your family's COBRA rights, you should keep the plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the plan administrator.

Your Right to Receive Certificate of Health Coverage

- The health care plans do not have any pre-existing condition limits. However, some health care plans limit benefits for health care problems (called pre-existing conditions) that you or your dependents have before coverage begins.

- A federal law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that prior health care coverage count towards satisfying a pre-existing condition limit of another employer's plan. In short, this makes your health coverage "portable" to the extent that you receive credit toward satisfying any pre-existing condition exclusion under a health plan based on coverage under a prior plan.

- Your coverage in one plan will count toward a pre-existing condition limit of another plan, provided you do not have a break in coverage between the old plan and the new plan of 63 or more days. (Under some state laws, this 63-day period may be extended for insured plans.) A waiting period under a new employer's plan does not count toward this 63-day period.

- HIPAA provides that you and your covered dependents are entitled to a certificate from your prior health plan to show evidence of prior health coverage. You may also need the certificate to buy, for yourself or your family, an individual insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

- If your Welfare Fund coverage ends, you and your covered dependents will receive a certificate that shows your period of health coverage under the Fund. You and your dependents also may request a certificate within 24 months of losing Welfare Fund coverage.

Privacy Notice

- This notice describes how health care information about you may be used and disclosed and how you can get access to this information.

The Fund's Pledge Regarding Health Information Privacy

- The privacy policy and practices of the Fund protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

Privacy Obligations of the Plan

- The Fund is required by law to:

- Make sure that health information that identifies you is kept private

- Give you this notice of the Fund's legal duties and privacy practices with respect to health information about you

- Follow the terms of the notice that is currently in effect

How the Plan May Use and Disclose Health Information about You

- The following are the different ways the plan may use and disclose your PHI:

- **For Treatment**. The plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the plan may advise an emergency room physician about the types of prescription drugs you currently take.

- **For Payment**. The plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the plan's terms. For example, the plan may receive and maintain information about surgery you received to enable the plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

- **For Health Care Operations.** The plan may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the plan's participants receive their health benefits. For example, the plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The plan may also combine health information about many plan participants and disclose it to the Fund's benefit consultant in summary fashion so it can decide what coverages the plan should provide. The plan may remove information that identifies you from health information disclosed to the consultant so it may be used without the consultant learning who the specific participants are.

- **To A Business Associate**. Certain services are provided to the plan by third party administrators known as "business associates." For example, the plan may input information about your health care treatment into an electronic claims processing system maintained by the plan's business associate so your claim may be paid. In so doing, the plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the plan will require its business associates, through contract, to appropriately safeguard your health information.

- **Treatment Alternatives**. The plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services**. The plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

- **Individual Involved in Your Care or Payment of Your Care**. The plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

- **As Required By Law**. The plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations

- The plan may also use or disclose your PHI under the following circumstances:

- **Lawsuits and Disputes**. If you become involved in a lawsuit or other legal action, the plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

- **Law Enforcement**. The plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

- **Workers' Compensation**. The plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws or other similar programs.

- **Military and Veterans**. If you are or become a member of the U.S. armed forces, the plan may release medical information about you as deemed necessary by military command authorities.

- **To Avert Serious Threat to Health or Safety**. The plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

- **Public Health Risks**. The plan may disclose health information about you for public heath activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

- **Health Oversight Activities**. The plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

- **Research**. Under certain circumstances, the plan may use and disclose your PHI for medical research purposes.

- **National Security, Intelligence Activities, and Protective Services**. The plan may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.

- **Organ and Tissue Donation**. If you are an organ donor, the plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

- **Coroners, Medical Examiners, and Funeral Directors**. The plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

Your Rights Regarding Health Information About You

- Your rights regarding the health information the plan maintains about you are as follows:

- **Right to Inspect and Copy**. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

- To inspect and copy health information maintained by the plan, submit your request in writing to the plan administrator. The plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

- **Right to Amend**. If you feel that health information the plan has about you is incorrect or incomplete, you may ask the plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the plan.

- To request an amendment, send a detailed request in writing to the plan administrator. You must provide the reason(s) to support your request. The plan may deny your request if you ask the plan to amend health information that was: accurate and complete; not created by the plan; not part of the health information kept by or for the plan; or not information that you would be permitted to inspect and copy.

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the plan has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations.

- To request an accounting of disclosures, submit your request in writing to the plan administrator. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.

- **Right to Request Restrictions**. You have the right to request a restriction on the health information the plan uses or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the plan not use or disclose information about a surgery you had.

- To request restrictions, make your request in writing to the plan administrator. You must advise: (1) what information you want to limit; (2) whether you want to limit the plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply.

- Note: The plan is not required to agree to your request.

- **Right to Request Confidential Communications**. You have the right to request that the plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address.

- To request confidential communications, make your request in writing to the plan administrator. The plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may write to the plan administrator to request a written copy of this notice at any time.

Changes to This Notice

- The plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the plan already has about you, as well as any information the plan receives in the future.

Complaints

- If you believe your privacy rights under this policy have been violated, you may file a written complaint with the plan administrator at the address listed on page 93. Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission complained of occurred.

- Note: You will not be penalized or retaliated against for filing a complaint.

Other Uses and Disclosures of Health Information

- Other uses and disclosures of health information not covered by this notice or by the laws that apply to the plan will be made only with your written authorization. If you authorize the plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the plan will no longer use or disclosure your PHI for the reasons covered by your written authorization; however, the plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

- If you have any questions about this notice, please contact the Fund office.

Employment Rights

- Being a participant in any of these plans does not grant any current or future employment rights. Plan participation is not an inducement or condition of employment. Your right to any payment is determined solely under the plan's provisions.

Events Affecting Your Coverage

If Your Employment Terminates

- If your employment ends, coverage for you and your covered dependents will stop on the first day of the month you or your employer fails to make any required contribution. If employment ends due to a disability, you may be eligible to continue to receive disability benefits (assuming you are eligible). If employment ends due to death or retirement, disability benefits terminate.

- When coverage ends, you may buy continued health care coverage for a limited time by paying the full cost of coverage plus 2% for administration. Your right to continuation of coverage under COBRA is protected by a federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). See **COBRA Continuation Coverage** in the **Plan Operation and Rights** section of this Summary Plan Description.

If You Become Disabled

- You are considered disabled if:

- An illness or injury (including pregnancy) prevents you from working
- You are under the care of an M.D. or D.O. in the United States

- If you become temporarily disabled, you will be credited with $90 per week during periods when you are eligible to receive weekly disability from the Fund or when you are entitled to receive weekly disability compensation under state workers' compensation statutes for an injury sustained in covered employment. You will be credited this amount for up to 52 weeks for any one continuous period of disability.

- If you are receiving workers' compensation benefits as a result of an injury sustained while you are on the job and employed as a Local 542 Operating Engineer, you must notify the Fund office immediately and provide satisfactory proof of disability in order to receive credit during periods of disability. Failure to do so will result in your disqualification from receiving credits for such disability.

If You Retire

- If you retire, you may be eligible for retiree Welfare benefits through the Welfare Fund. See the ***Retiree Medical Benefits Summary Plan Description (SPD)*** for information about the criteria necessary for retiree coverage.

- If you fail to meet the requirements for retiree coverage, you and your eligible dependents may be eligible to continue health care coverage for a limited time by paying the full cost of coverage plus 2% for administration. (see **COBRA Continuation Coverage** in the **Plan Operation and Rights** section of this Summary Plan Description).

If You Die

- If you die, and you and your dependent(s) were eligible for coverage on the day of your death, your eligible dependents may be able to continue coverage for a limited time by paying the full cost of coverage plus 2% for administration. (see **COBRA Continuation Coverage** in the **Plan Operation and Rights** section of this Summary Plan Description.)

If Your Dependents Are No Longer Eligible

- Your dependents are no longer eligible if:

- They reach age 19 (age 23 if a full-time student at an accredited educational institution); however, coverage may continue for mentally and physically handicapped children who are covered under the plan and handicapped at age 19 (or age 23, if applicable), provided they depend on you for their principal financial support and maintenance because of the handicap and provided they remain continuously disabled;

- They become ineligible because of events such as marriage, divorce, full-time employment of a child, etc.

- A child may be covered until the day he or she reaches the limiting age (age 19 or age 23).

- When coverage ends, your dependents may buy continued health care coverage for a limited time if they pay the full cost of coverage plus 2% for administration. (see **COBRA Continuation Coverage** in the **Plan Operation and Rights** section of this Summary Plan Description.)

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Future of the Plan

- While the IUOE Welfare Fund of Eastern PA and DE intends to continue the welfare benefits indefinitely, it is difficult to predict the future; therefore, an unqualified commitment to continue the program at any particular level of benefits is impossible. Thus, the Fund reserves the right to modify, amend, suspend, or terminate coverage, at any time for any reason.

- Any amendment, however, may not deprive you of any benefit payments to which you are entitled at the time of amendment or termination. Should the program be modified, any claims incurred prior to the amendment date will be paid in accordance with the plan provisions in effect prior to the modification. Any claims incurred on or after the amendment date will be paid in accordance with the new plan provisions.

- Should the program terminate, all eligible claims incurred prior to the date of termination will be paid to the extent of available assets if submitted within a reasonable period of time, as determined by the plan administrator and/or claims administrator.

- Any claims incurred after the date of termination will not be considered for payment.

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Plan Operation and ERISA Rights

Please see the **Plan Operation and Rights** section in this SPD for information on how the plan is administered and funded, the agent for service of legal process, plan numbers, claims appeal procedures, and your rights under the Employee Retirement Income Security