International Union of Operating Engineers of Eastern Pennsylvania and Delaware

Welfare and SUB Funds Summary Plan Description

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A Message from the Board of Trustees

The Board of Trustees of the International Union of Operating Engineers of Eastern Pennsylvania and Delaware (IUOE Local 542) Welfare and SUB Funds are pleased to provide you with valuable Fund-sponsored plans. These summary plan descriptions (SPDs) provide a detailed description of the benefits provided by the Welfare and SUB Plans.

These benefits are provided by contributing employers as a result of collective bargaining or participation agreements with the International Union of Operating Engineers of Eastern Pennsylvania and Delaware and/or the Board of Trustees of each of the two Funds.

The following introductory section highlights key features of your benefits, and is intended as an overview only. For complete information and a detailed description of each plan, please refer to the related sections of the booklet.

Depending on your Benefit Level, you may be eligible for some or all of the following benefits:

- Medical
- Vision
- Laser Eye Surgery
- Hearing Aid
- Dental
- Prescription Drug
- Employee Assistance Program (EAP)
- Mental Health and Substance Abuse
- Weekly Disability
- Death and Accident
- Supplemental Unemployment Benefit (SUB)

These summary plan descriptions (SPDs) summarize the provisions of the plans provided by the International Union of Operating Engineers of Eastern Pennsylvania and Delaware Local 542 Welfare and SUB Funds to active members on or after January 1, 2016. If any conflicts arise between these SPDs and the applicable plan documents, the plan documents will govern in all cases. The Trustees reserve the right to amend, modify, or terminate the plans at any time for any reason. You should not rely on an oral description of the plans because written terms of the plans will always govern. These SPDs do not constitute a contract of employment. For more information about the plans, contact the Fund office.

Highlights of Your Benefits

Generally, you and your eligible dependents may be able to participate in all or some of the plans described in this summary plan description if you are employed by a contributing employer who is making contributions on your behalf to the Funds as a result of a collective bargaining or participation agreement.

Plan	Description	Who Is Eligible
Medical	Preferred Provider Organization (PPO), including inpatient hospital benefits, administered by Independence Blue Cross	P1, C2
	Inpatient hospital and medical/surgical benefits administered by Independence Blue Cross and the Fund Office	P3
	Inpatient hospital benefits (does not include physician charges) administered by Independence Blue Cross	P4
Vision	You may receive up to $300 per person every two years for an exam, frames, and lenses or contact lenses. Benefits administered by Vision Benefits of America (VBA)	P1, C2
Laser Eye Surgery	You may receive 80% of the cost of laser eye surgery, up to a maximum charge of $1500 per eye, once per lifetime	P1, C2
Hearing Aid	You may receive 100% of the cost of a hearing aid, up to a maximum $1000 payment per device (maximum of 4 devices per lifetime)	P1, C2
Dental	Dental PPO through *Fidelio* Insurance Company	P1, C2
Prescription Drug	You pay $10 for generic, $20 for preferred brand, and $40 for non-preferred brand at retail pharmacy. Mail order is two times the retail copay	P1, C2
	You receive an Express Scripts discount card for discounted rates on prescriptions at participating pharmacies	P3, P4
Employee Assistance Program (EAP)	Free short-term counseling over the phone, 24 hours a day, seven days a week. The Welfare Fund also pays the full cost for up to five face-to-face visits with a trained mental health professional. Benefits administered by Allied Trades Assistance Program (ATAP)	P1, P3, P4, C2
Mental Health and Substance Abuse	Coverage for all or a portion of your inpatient and/or outpatient care. All treatment must be pre-certified or benefits will not be paid	P1, C2
	Coverage for all or a portion of your inpatient care. (P4 covered for inpatient hospital charges only.) All treatment must be pre-certified or benefits will not be paid	P3, P4
Weekly Disability	You may receive up to $350 per week for up to 52 weeks in a 52 week period if illness or injury keeps you from working. You must be under the care of an M.D., D.O., or D.P.M. in the United States	P1, C2
Death and Accident	Your beneficiary may receive up to $5,000 if you die, and up to an additional $5,000 if your death is deemed an accident. These benefits are administered by the Standard Insurance Company	
Supplemental Unemployment Benefit (SUB)	If you are unemployed due to a layoff or disability, you may be eligible for benefits from the SUB Fund. You may receive $125 per week for up to 39 weeks for any one period of unemployment or for all periods of unemployment during any 52 consecutive week period	

Whom to Call

Plan or Program	Administrative Information	Contact Information
Preferred Provider Organization (PPO) Medical Plan	Independence Blue Cross	1-800-ASK-BLUE (1-800-275-2583) www.ibx.com You must pre-authorize certain services or penalties will apply.
Vision Plan	Vision Benefits of America (VBA)	1-800-432-4966 www.vbaplans.com
Laser Eye Surgery Plan **Hearing Aid Plan**	Welfare Fund	1-800-233-2043 www.iuoe542funds.com
Dental Plan	*Fidelio* Insurance Company	1-800-262-4949 www.fideliodental.com
Prescription Drug Plan	Express Scripts	1-866-294-1558 www.express-scripts.com
Employee Assistance Program (EAP)	Allied Trades Assistance Program (ATAP)	1-800-258-6376 alliedtrades-online.com
Mental Health and Substance Abuse Benefits	Allied Trades Assistance Program (ATAP)	1-800-258-6376 You must precertify treatment or benefits will not be paid.
Weekly Disability Benefits	Welfare Fund	1-800-233-2043 www.iuoe542funds.com Your disability must be certified by an M.D., D.O. or D.P.M. within the United States.
Death and Accident Benefits	Pension or Welfare Fund	1-800-233-2043 www.iuoe542funds.com
Supplemental Unemployment Benefit (SUB)	SUB Fund	1-800-233-2043 (information) 1-888-542-8511 (automated system to apply for benefits) www.iuoe542funds.com
Personal Information Changes (such as address/ name changes)	Welfare Fund	1-800-233-2043 If you are adding/dropping dependents: You must notify the Fund within 30 days of a family status change.

Benefits Eligibility

Welfare Fund

To be eligible for Welfare Fund benefits, your employer must be making contributions to the Fund as the result of a collective bargaining or participation agreement AND you must be credited with a certain number of hours worked (your Work Hours) or employer contributions in a specified Work Period (see **When You Become Eligible for Coverage** in the **Welfare** section). You become credited with Work Hours when they are reported to the Fund. The chart below shows the Work Hours required for Parent Body at each Benefit Level. C-branch eligibility is based on employer contributions and the level of required contributions is contained in the Collective Bargaining or participation agreement. In order to initially qualify for benefits, you must be credited with the minimum requirements.

The Benefit Levels and Covered Benefits

P1	C2	P3	P4	Covered Benefits
900 or more Work Hours	Contribution defined in bargaining agreement	500–899 Work Hours	200–499 Work Hours	
				Medical
X	**X**			▪ PPO medical plan (includes inpatient hospital coverage)
		X		▪ Inpatient medical/surgical (including physician charges)
			X	▪ Inpatient hospital benefit (does not include physician charges)
X	**X**			**Vision**
X	**X**			**Laser Eye Surgery**
X	**X**			**Hearing Aid**
X	**X**			**Dental**
				Prescription Drug
X	**X**			▪ Three-tiered
		X	**X**	▪ Discount through ESI discount card
X	**X**	**X**	**X**	**Employee Assistance Program**
				Mental Health and Substance Abuse
X	**X**			▪ Inpatient and outpatient care
		X		▪ Inpatient care (including physician charges)
			X	▪ Inpatient hospital benefit (does not include physician charges)
X	**X**			**Weekly Disability (if you qualify)**
X	**X**	**X**	**X**	**Death and Accident (if you qualify)**

Supplemental Unemployment Benefit (SUB) Fund

You may be eligible if you are working for an employer who is required to make contributions to the SUB Fund as the result of a collective bargaining or participation agreement. You become eligible for coverage after you have been credited with at least 500 hours in the applicable 12-month period.

Welfare

Eligibility and Coverage

When You Become Eligible for Coverage

After you have been credited with sufficient hours or contributions in a Work Period, you will be eligible to participate in the corresponding Benefit/Eligibility Period. Each Work Period is 3 consecutive calendar quarters, and the corresponding Benefit/Eligibility Period is the 2nd calendar quarter following the Work Period. This is shown (by way of example, using 2017 Benefit/Eligibility Periods). This is shown (by way of example, using 2017 Benefit/Eligibility Periods) in the following chart. You will continue to be entitled to benefits in subsequent Benefit/Eligibility Periods, providing you continue to meet the hours or contribution requirements. Statements containing eligibility are provided to you quarterly, if your eligibility is hours-based.

Parent Body

Benefit/Eligibility Period			Work Period								
1st Qtr 2017			3rd Qtr 2016			2nd Qtr 2016			1st Qtr 2016		
Jan	Feb	Mar	Jul	Aug	Sep	Apr	May	Jun	Jan	Feb	Mar
2nd Qtr 2017			4th Qtr 2016			3rd Qtr 2016			2nd Qtr 2016		
Apr	May	Jun	Oct	Nov	Dec	Jul	Aug	Sep	Apr	May	Jun
3rd Qtr 2017			1st Qtr 2017			4th Qtr 2016			3rd Qtr 2016		
Jul	Aug	Sep	Jan	Feb	Mar	Oct	Nov	Dec	Jul	Aug	Sep
4th Qtr 2017			2nd Qtr 2017			1st Qtr 2017			4th Qtr 2016		
Oct	Nov	Dec	Apr	May	Jun	Jan	Feb	Mar	Oct	Nov	Dec

If your reported hours are less than 200, you may be able to continue coverage under COBRA.

C-Branch

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
May	June	August
June	July	September
July	August	October
August	September	November
September	October	December
October	November	January
November	December	February
December	January	March

If your employer contributions are less than the required amount 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
- Children under age 26
- 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, and stepchildren.

A child may be covered until the end of the month in which he or she reaches the age limit (age 26).

If you are legally bound to provide full and permanent support for a child who is neither your biological child, legally adopted child nor your stepchild, that child will be eligible for coverage, but only if that child is under age 19, or, if a full-time student at an accredited educational institution, is under 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 children for whom you are required to provide health care coverage under a Qualified Medical Child Support Order (QMCSO). 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 will be required to supply proof of marital status. You will also be required to provide a copy of your child's birth certificate or other documentation confirming their status as your eligible dependent. 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 26. 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 other reason 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 (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.

Special Enrollment Rights for Individuals Eligible for the Children's Health Insurance Program (CHIP)

Effective April 1, 2009, if you or a dependent are eligible for but not enrolled in coverage under the IUOE Welfare Fund, you may enroll in coverage if:

- You or your dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility for that coverage; or
- You or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP

Time limits apply to these special enrollment rights. You must request enrollment in the Welfare Fund:

- within **60** days of the date you or your dependent lost Medicaid or CHIP coverage ; or
- within **60** days of the date your eligibility for premium assistance is determined under Medicaid or CHIP

Changes Must Be Consistent

All changes must be made within 31 days (or 60, as applicable) 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 or participation agreement. The following buy-up option is for Parent Body members only. C-branch members may be eligible to continue coverage through COBRA (see **COBRA Continuation Coverage** in the **Plan Operation and Rights** section of this SPD).

Buy-Up Option (Parent-Body only)

The Welfare Fund offers a special provision for your added protection. During some Work Periods your employer's contributions to the Fund may not be sufficient to provide the Welfare Fund coverage you want. To assure that you and your family have the coverage you feel you need, especially during periods of low employment or disability, you may have the option to make voluntary contributions in order to buy up to the Benefit Level you desire.

The Fund Office will notify you if you become ineligible for full benefits. You may have the option to pay for the Benefit Level—and coverage—you need.

The Fund office will notify you if you are eligible to buy up. If you are eligible, you may make voluntary contributions to increase your Benefit Level for any Work Period in which your employer contribution is insufficient for the Benefit Level you want.

The buy-up option is limited to 18 consecutive months. Once you have made voluntary contributions for 18 consecutive months your eligibility for the buy-up option will cease. You may be eligible to buy-up again once you have established P1 coverage through hours worked for a minimum of nine consecutive months.

The Buy-Up Formula					
Part 1	Required Work Hours for Desired Benefit Level	–	Actual Credited Work Hours	=	Eligibility Hours Short
Part 2	Eligibility Hours Short	x	$.50	=	Monthly Buy-Up Charge (to a maximum of $500)

Example

Assume you are credited with 200 Work Hours for the Work Period from January 2016 to September 2016. Therefore, from January through March 2017, you will be eligible for the P4 Benefit Level. However, assume you have the option to buy-up to either Benefit Level P1 or P3 and you want to buy up to level P1.Your monthly contribution of $300 would be calculated as follows:

	900		200		700
Part 1	(Required Work Hours for Desired Benefit Level)	–	(Actual Credited Work Hours)	=	(Eligibility Hours Short)
Part 2	700	x	$.50	=	$350

Benefit Level to Which You May Buy Up

The Fund office will notify you if you are eligible to buy up (see **Schedule of Notification and Payment Due** below). Choose your buy-up option carefully. You may not buy up more than one level above the Benefit Level for which you were last eligible, through hours worked in covered employment, unless it is an "initial buy-up." Your future buy-up options will depend on the choice you make initially and with each subsequent buy-up opportunity.

If you are eligible for Benefit Level	You may be allowed to buy up to:	
	P1	**P3**
P3	**X**	
P4	**X**	**X**

Schedule of Notification and Payment Due

Quarterly statements containing eligibility and contribution information are provided before each Benefit/Eligibility Quarter. If you are eligible for the buy-up option, you will receive a buy-up notice in the mail. You must make your payment by the indicated due date. Coverage will take effect in the corresponding Benefit/Eligibility Quarter.

Work Period	Quarterly Statement Mailed	"Buy-Up" Notices Mailed	Payment Due	Benefit/ Eligibility Quarter
January–September	**November 15**	December 5 January 5 February 5	December 25 January 25 February 25	January February March
April–December	**February 15**	March 5 April 5 May 5	March 25 April 25 May 25	April May June
July–March	**May 15**	June 5 July 5 August 5	June 25 July 25 August 25	July August September
October–June	**August 15**	September 5 October 5 November 5	September 25 October 25 November 25	October November December

How to Make a Payment

You must be a United States resident in order to buy up. Your contribution must be paid by the due date prior to the month in which your eligibility would start. You may make your contribution by personal check, credit card or money order payable to the Welfare Fund. Or, you may pay in cash at the Fund Office when a receipt can be provided.

Please note, if your check is returned by the bank for insufficient funds, you will be charged a service fee—and you may lose your eligibility for the buy-up option if there is not enough time to resubmit your check before your payment due date. Additionally, if two of your personal checks are returned by the bank for insufficient funds, any future payments must be made either by cashier's check or in cash.

Your buy-up contribution can be made only for the Benefit/Eligibility Quarter immediately following the Work Period for which your employer contributions were insufficient for the Benefit Level you wanted. You may not pay in advance for future Benefit/Eligibility Quarters.

If You Are Working Out of the Area (Reciprocity)

You may be eligible for Welfare Fund coverage for time that you work in another area that has adopted the International Union of Operating Engineers Eastern District Reciprocal Agreement. This is known as reciprocity. The agreement was established so that a member could continue to be eligible for and receive benefits under his own local welfare fund, regardless of where in the country he may be working. The Fund also has agreements with other funds across the country. In order to receive credit for hours worked in the jurisdiction of a reciprocating welfare fund, you must notify the Fund Office in writing with the:

- Name of your employer
- Local union in whose jurisdiction you are working
- Date you began such work

The Fund Office will ask the reciprocating local to refund contributions paid on your behalf. When the contributions are received by the Fund, your account will be credited accordingly and benefit eligibility will be determined.

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 medical 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 or participation agreement.
Eligible Dependents	Your eligible dependents include your spouse and your children under age 26.
Cost	Your employer makes contributions to the Welfare Fund on your behalf. Your hours worked (called your Work Hours) or your employer contributions determine your Benefit Level.
Continuation Coverage	During some Work Periods, your Work Hours or employer contributions may not be sufficient to provide the medical coverage you want. You may be able to make contributions in order to buy the medical coverage you desire.
Benefit Level	▪ Benefit Levels P1 and C2 are eligible for the PPO ▪ Benefit Level P3 is eligible for inpatient medical/surgical and hospital benefits. You may be able to "buy up" for PPO coverage ▪ Benefit Level P4 is eligible for inpatient hospital benefit only. You may be able to "buy up" for inpatient medical/surgical or PPO coverage.
When Your Coverage Begins	After you have been credited with at least 200 Work Hours in a 9-month Work Period (Parent Body), or the required Employer Contributions (C-branch) you will be eligible to participate in the medical plan option for which you qualify in the corresponding Benefit/Eligibility Period.
Medical Plan Options	Depending on your Benefit Level, you may be eligible for: ▪ Preferred Provider Organization (PPO) medical plan through Independence Blue Cross—providing inpatient and outpatient hospital and medical/surgical benefits ▪ Inpatient medical/surgical AND inpatient hospital benefit through Independence Blue Cross and the Fund Office ▪ Inpatient hospital benefit only (does not include physician charges) through Independence Blue Cross
What is a Preferred Provider Organization (PPO)?	A PPO provides care through a carefully selected network of doctors and hospitals who 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 PPO network (called "out-of-network"). Generally, your out-of-pocket costs are lower when you use an in-network provider.
Claim Submission	Claim form 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 Work Hours fall below 200 in each subsequent 9-month Work Period (Parent Body) or your Employer Contributions fall below the minimum requirement (C-branch).
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-ASK BLUE (1-800-275-2583) ▪ For questions about eligibility, call the Fund office at 1-800-233-2043

Preferred Provider Organization (PPO) for Benefit Levels P1and C2

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 website 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:

Step 1: Eligible for Coverage

⇓

Step 2: Each Time You Need Medical Care, You Choose…

⇓	⇓
In-Network Care	**Out-of-Network Care**
You receive care from providers who are in the PPO network.	You receive care from providers who are **NOT** in the PPO network.
⇓	⇓

Step 3: Receiving Benefits

⇓	⇓
You receive the highest level of benefits and do not file claim forms.	You pay more out of your own pocket and you must file claims.

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 website 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 and family expenses, 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 are examples of out-of-network services do not count toward your annual deductible:

- Emergency care
- 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-Pocket Maximum Protects You

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

When the out-of-pocket expenses for one person reach the out-of-pocket maximum, the plan pays 100% of the eligible 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 in-network out-of-pocket maximum is $2,000 for an individual/$4,000 for a family (including eligible Mental Health expenses covered through ATAP). Your annual out-of-network maximum is $3,000 for an individual/$6,000 for a family (including eligible Mental Health expenses covered through ATAP).

Expenses Not Counted Toward Your Out-of-Pocket Maximum

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

- The annual deductible (out-of-network only)
- Charges that exceed the plan allowance
- Charges denied because they are not covered under the Plan or not medically necessary/medically appropriate
- Penalties you incur for not pre-authorizing certain services as required by the plan (see **You Must Pre-Authorize Certain Care**)

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 for non-essential health benefits is limited to a $1,000,000 lifetime maximum. When you reach the lifetime maximum, all benefits will cease. The following are considered essential health benefits: (1) Ambulatory patient services; (2) Emergency services; (3) Hospitalization; (4) Maternity and newborn care; (5) Mental health and substance use disorder services, including behavioral health treatment; (6) Prescription drugs; (7) Rehabilitative and habilitative services and devices;(8) Laboratory services; (9) Preventive and wellness services and chronic disease management; and (10) Pediatric services, including oral and vision care.

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-pocket maximum. Also, if you fail to pre-authorize and the service is determined to be not medically necessary/ medically appropriate, NO payment will be made.

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

Please note: the fact that a service or item is subject to pre-certification DOES NOT guarantee coverage. The terms and conditions of the Plan determine if these services or items are covered benefits.

To ensure that you receive the full benefits to which you are entitled, call for pre-authorization for the following services, which are subject to change by Independence Blue Cross:

Inpatient services

- Elective surgical and non-surgical inpatient admissions
- Long term acute care (LTAC) facility admissions
- Skilled nursing facility admissions
- Acute rehabilitation admissions
- Inpatient hospice admissions

Procedures

- Obesity surgery
- Cochlear implant surgery and associated supplies/bone-anchored (osseointegrated) hearing aids, implantable bone conduction hearing aids
- Carticel (ACI), osteochondral allograft, and autograft transplantations
- Uvulopalatopharyngoplasty (UPPP), including laser-assisted

Reconstructive procedures and potentially cosmetic procedures

- Blepharoplasty/ptosis repair
- Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants
- Canthopexy/canthoplasty
- Cervicoplasty
- Chemical peels
- Dermabrasion
- Excision of excessive skin and/or subcutaneous tissue
- Genetically and bio-engineered skin substitutes for wound care
- Hair transplant
- Injectable dermal fillers
- Keloid removal
- Lipectomy, liposuction, or other excess fat-removal procedure
- Bone graft, genioplasty, and mentoplasty
- Otoplasty
- Rhinoplasty
- Rhytidectomy
- Scar revision
- Skin closures including:
  - Skin grafts
  - Skin flaps
  - Tissue grafts
- Sex reassignment surgery
- Surgery for varicose veins, including perforators and sclerotherapy

Any procedure, device, or service that may potentially be considered experimental, or investigational including:

- New emerging technology/procedures, as well as existing technology and procedures applied for new uses and treatments

Elective (nonemergency) ground, air, and sea ambulance transportation

Outpatient private-duty nursing

Day rehabilitation programs

Radiology

- PET scans
- MRI
- MRA
- CT
- Nuclear cardiology
- Echocardiography services
  - Stress echocardiography (SE)
  - Testing transthoracic echocardiography (TTE)
  - Transesophageal echocardiography (TE)

All home-care services (including infusion therapy in the home)

Prosthetics/orthoses including:

- Custom limb prosthetics including accessories/components
- Custom ankle-foot orthoses
- Custom knee-ankle-foot orthoses
- Custom knee braces

Selected durable medical equipment (DME)

- Bone growth stimulators
- Bone-anchored hearing aids
- Continuous positive airway pressure (CPAP) devices and bi-level (Bi-PAP) devices
- Dynamic adjustable and static progressive stretching devices (excludes CPMs)
- Electric, power, and motorized wheelchairs including custom accessories
- External defibrillator and associated accessories
- High frequency chest wall oscillation generator system
- Manual wheelchairs with the exception of those that are rented
- Negative pressure wound therapy
- Neuromuscular stimulators
- Power operated vehicles (POV)
- Pressure reducing support surfaces including:
  - Air fluidized bed
  - Non powered advanced pressure reducing mattress
  - Powered air flotation bed (low air loss therapy)
  - Powered pressure reducing mattress
- Push rim activated power assist devices
- Repair or replacement of all DME items, as well as orthoses and prosthetics that require precertification
- Speech generating devices

Medical foods

Hyperbaric oxygen therapy

Proton beam therapy

Sleep studies (facility based)

All transplant procedures, with the exception of corneal transplants

Autism Spectrum Disorders (when covered under Medical, not Mental Health, plan)

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	$2,000 per person/$4,000 per family	$3,000 per person/$6,000 per family
Lifetime Maximum	Unlimited	$1,000,000 (for non-essential health benefits)
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%	70%
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 (up to 70 days coverage per calendar year)
Other Inpatient and Outpatient Services		
Outpatient Surgery[2]	100% after $75 copay	70% after deductible
Emergency Room	Visits 1 to 4: $100 copay/visit Visits 5 to 10: $200 copay/visit Visits 11+: $500 copay/visit (per calendar year) (copay waived if admitted)	Visits 1 to 4: $100 copay/visit Visits 5 to 10: $200 copay/visit Visits 11+: $500 copay/visit (per calendar year) (copay waived if admitted)
Urgent Care Center	100% after $50 copay	70% after deductible
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 Lab Tests and X-Rays in "What the Medical Plan Pays" for more details.

Plan Feature	In-Network	Out-of-Network[1]
Other Inpatient and Outpatient Services (Continued)		
Skilled Nursing Facility[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
Respiratory Therapy	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) orthoptic/pleoptic therapy limited to 8 sessions lifetime maximum	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 Copay per rental period or item purchased[2]	100% after $20 copay	70% after deductible
Prosthetics[2]	100% after $20 copay	70% after deductible
Cranial Prosthetesis (as a result of hair loss due to chemotherapy or radiation)[3]	100% after $20 copay to a maximum payment of $500 per lifetime	100% after $20 copay to a maximum payment of $500 per lifetime
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.

[3]This benefit is administered directly through the Fund Office. Contact the Fund office at 800-233-2043 for eligibility and claim submission.

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* Insurance Company.

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. Coverage for 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 the required copayment for each visit. Visits to in-network specialists are covered at 100% after you pay the required copayment 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.

See "You Must Pre-Authorize Certain Care" for a list of Durable Medical Equipment that requires pre-authorization. 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 the required copay. Your copay may vary depending on the number of times you utilize emergency care during a calendar year. 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 the same copay as required for your original emergency room visit.

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 covered or 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, respiratory therapy, and hydrotherapy
- Newborn nursery care
- 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

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 "You Must Pre-Authorize Certain Care" 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 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.HCSolutionsCorp.com. Make sure you have the member's Social Security number available when you call or access the website.

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 your applicable 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, some of which require pre-authorization:

- Surgical supplies
- Blood plasma or whole blood not replaced by or for the patient
- Chemotherapy
- Radiation therapy
- Infusion therapy
- Dialysis treatment
- Anesthesia
- Oxygen and other gases and their administration
- Diabetic equipment and supplies (pre-authorization required for the purchase of equipment over $500), 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)

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.

Diabetic Supply Program

The plan covers certain diabetic supplies at 100% when provided through Solutions for Health. If your physician prescribes diabetic supplies, contact the Fund office or Solutions for Health directly at 800-665-8125. You can also email Solutions for Health at ordering@solutions4h.com.

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. The eligible benefit is limited to 360 hours per calendar year.

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 the applicable copay per visit.

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 your applicable copay per visit. Out-of-network adult preventive care is covered at 70% after you meet any applicable 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.

Preventive Care for Children

- Routine immunizations are covered 100% for dependent children when you use in-network providers (70% with no deductible for out-of-network providers).
- Preventive care for children under age 18 is covered at 100% when you use in-network providers (70% coinsurance apply if out-of-network), according to the schedule below. Preventive care for children 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

Under the provisions of PPACA, some preventive services for both adults and children are coverable at 100% in-network. Please contact the Fund office or Independence Blue Cross for additional information.

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, including repairs and replacements, 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 the applicable 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, combined in and out of network.

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 calendar year for in- and out-of-network care combined.

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 activities of 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, as determined by Independence Blue Cross, the plan will also cover the charges of a surgical assistant provided the surgeon and surgical assistant are not part of the same physicians' group.

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, 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.

Urgent Care

Urgent care received at an in-network facility is covered at 100% after you pay the required copay. Out-of-network urgent care is covered at 70% after you meet the applicable deductible.

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 fertility diagnosis or testing of infertility for anyone other than a member or the spouse of a member
- 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 unless otherwise listed as covered in this description
- 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 or housing, 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 mentally challenged 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, pervasive development disorders, attention deficit disorder, learning disabilities, behavioral problems, or mental sub-normality that extends beyond traditional medical management; or treatment or care to affect 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 drugs that do not meet federal or state law requirements for a prescription for that diagnosis
- 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 and IBC identification 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.

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 or 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 Person

A "covered person" is an individual, including dependents, who is eligible for benefits under the plan as a result of meeting eligibility and all other plan criteria to establish eligibility for benefit coverage.

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
  - Short procedure unit
  - Skilled nursing facility
  - Urgent Care Center
- 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
  - Urgent Care Center
- 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 "investigative" are used to describe services that address a drug, biological product, device, medical treatment, or procedure that meets any of the following criteria:

- Is the subject of ongoing Clinical Trials;
- Is the research, experimental, study or investigational arm of an ongoing Clinical Trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its safety, its effectiveness, or its effectiveness as compared with a standard means of treatment or diagnosis;
- Is not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition;
- Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Covered Person's particular condition;
- Is generally recognized, based on Reliable Evidence, by the medical community, as a diagnostic or treatment intervention for which additional study regarding its safety and effectiveness for the diagnosis or treatment of the Covered person's particular condition is recommended

Unless required by Federal law, 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.

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 as generally recognized and accepted by the medical community
- Not primarily for your immediate family's 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 may 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 service 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.

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, tuberculosis, or for custodial care.

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.

Urgent Care Center

An urgent care center is a medical facility that employs board-certified doctors for the treatment of less serious medical conditions. Examples of illness or injury that can be treated at an Urgent Care center include:

- Stitches
- X-ray
- Sprain, strain
- Nausea, vomiting, diarrhea
- Bumps, cuts, scrapes
- Cough, sore throat
- Ear or sinus pain
- Minor fever, colds
- Rash

Seek treatment at a hospital Emergency Room, not an Urgent Care center, for the life-threatening medical situations described under “Emergency Care.”

Medical/Surgical Benefits for Benefit Level P3

Benefit Level P3 provides only inpatient coverage for you and your eligible dependents. This coverage includes physician charges while you are an inpatient and is subject to the same limitations and exclusions listed under the PPO.

Coverage for Inpatient Hospital Charges

Inpatient hospital charges are administered through Independence Blue Cross. When you use in-network providers, the plan covers:

- 100% of eligible inpatient hospital charges after $75 copay per day (up to $375 maximum per admission) up to 365 days per calendar year
- 100% of eligible charges for Hospice care
- 100% of eligible charges for Short Procedure Unit after $75 copay
- 100% of eligible charges for Skilled Nursing Facility

If you use out-of-network providers, the plan generally covers eligible expenses at 70% after you meet a $300 per person/$600 per family deductible.

All of these services require pre-certification. See **"You Must Pre Authorize Certain Care"** for an explanation of penalties for failure to pre-certify.

Coverage for Inpatient Medical/Surgical Charges

Inpatient medical/surgical charges are administered through the Welfare Fund. The plan covers:

- Inpatient consultations
- Surgery
- Anesthesia
- Inpatient doctor visits

You have the freedom to use any medical provider of your choice. There are no in-network or out-of-network providers. Because there is no network, you are responsible for the difference between the amount charged by the provider and the amount paid by the Welfare Fund.

Summary of Inpatient Medical/Surgical Benefits

Plan Feature	Benefit
Inpatient Consultations	100% first $50 per admission, 80% thereafter
Surgery	100% first $2,000, 80% thereafter
Anesthesia	100% first $500, 80% thereafter
Inpatient Doctor Visits	100% first $25 per day (first 70 days), 80% thereafter

Lifetime Maximum Benefit

There is no lifetime maximum benefit on medical/surgical expenses relating to one illness or injury.

Filing Inpatient Hospital Claims

Inpatient hospital claims are processed by Independence Blue Cross. See **"Filing Medical Claims"** for information about filing in and out of network inpatient hospital claims.

Filing Inpatient Medical/Surgical Claims

Inpatient medical/surgical claims are processed directly by the Welfare Fund office. 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:

IUOE Welfare Fund
P.O. Box 1627
Fort Washington, PA 19034-3257

You should file claims within **90** days of incurring the expense. In any case, all inpatient 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.

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.

Calling the Fund Office

The Fund Office can answer questions about your benefits, claims, and how the plan works.

To reach the Fund Office, call 1-800-233-2043.

Medical/Surgical Benefits for Benefit Level P4

Benefit Level P4 provides only inpatient hospital coverage for you and your eligible dependents. This coverage does not include physician charges while you are an inpatient. Your coverage under benefit level P4 is subject to the same limitations and exclusions listed under the PPO.

Coverage for Inpatient Hospital Charges

Inpatient hospital charges are administered through Independence Blue Cross. The plan covers:

- 100% of eligible inpatient hospital charges after $75 copay per day (up to $375 maximum per admission) up to 365 days per calendar year
- 100% of eligible charges for Hospice care
- 100% of eligible charges for Short Procedure Unit after $75 copay
- 100% of eligible charges for Skilled Nursing Facility

All of these services require pre-certification. See **"You Must Pre Authorize Certain Care"** for an explanation of penalties for failure to pre-certify.

Filing Inpatient Hospital Claims

Inpatient hospital claims are processed by Independence Blue Cross. See **"Filing Medical Claims"** for information about filing in and out of network inpatient hospital claims.

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.

Calling the Fund Office

The Fund Office can answer questions about your benefits, claims, and how the plan works.

To reach the Fund Office, call 1-800-233-2043.

Other Benefits

Vision Care Plan Highlights

The Fund offers a vision care plan, administered through Vision Benefits of America (VBA). 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 or participation agreement. You must have benefit level P1 or C2 to be eligible for Vision benefits. Levels P3 and P4 are not eligible for Vision Care benefits.
Eligible Dependents	Your eligible dependents include your spouse and children under age 26.
When Your Coverage Begins	After your employer has made the minimum required contribution in a work period, you will be eligible to participate in the corresponding benefit/eligibility period.
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. Your benefit may be up to $300 per covered person every 24 months for an exam, lenses, frames, and contact lenses.
Claim Submission	Claim form 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 for vision coverage if your employer contributions to the Welfare Fund on your behalf fall below the minimum required amount.
Questions	Call VBA at 1-800-432-4966.

The Vision Care Plan

What the Fund Pays

The Fund pays up to $300 for you and $300 for each covered family member in a 24-month period for an exam, frames, and lenses or contact lenses. The plan is designed to fully cover your visual needs rather than cosmetic lens and frames options. There may be extra costs involved if, for example, you select coated lenses; a frame that costs more than the plan's allowance; elective contact lenses; rimless frames. Note that the plan covers only one exam, one frame, one set of lenses or one supply of contact lenses in a 24-month period. Your supply of contact lenses will vary, depending the choices you make, but the total benefit cannot exceed the plan allowance.

Eligible dependent children under age 19 are eligible for a vision exam and, if necessary, new lenses every 12 months. All other eligible plan participants are eligible for a vision exam and new lenses once every 24 months. Frames are available to all plan participants, including dependent children under age 19, once in a 24-month period.

How to Use the Plan

You may see any vision care provider of your choice. When you choose to obtain services from a VBA Participating Provider, the plan covers exams, professional services, lenses and frames at no expense to you, if the materials selected fall within the Plan's allowance. Prior to receiving benefits, you can check your eligibility and find a VBA Participating Provider near you by either calling VBA at 1-800-432-4966 or visiting their website at www.vbaplans.com. If you choose to use a non-Participating Provider, you pay the cost of the treatment and materials (e.g., lenses, frames) and obtain an itemized receipt. Your receipt must include the following:

- Patient's name
- Member's Name and Social Security Number
- Provider name, address, and taxpayer ID number
- Date services began
- Services and materials received
- Charges
- The type of lenses the patient received

You will be reimbursed according to the reimbursement schedule. You may be billed for amounts exceeding the reimbursement schedule.

Mail your VBA claim form and your receipt to:

Vision Benefits of America
300 Weyman Plaza
Suite 400
Pittsburgh, PA 15236-1588

You are not required to use the same Provider, whether Participating or non-Participating for both an exam and any materials. For example, you may decide to use one Provider for your eye exam and another Provider to obtain any required materials such as lenses, frames, contact lenses.

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
  - Blended lenses
  - Lenticular
  - Progressive
- Frames
- Contact lens evaluation and fitting
- Contact lenses (in lieu of glasses):
  - Disposable
  - Standard

Vision Expenses Coverable Only When You Use a Participating Provider

- Solid or gradient lens tints
- UV Protective Coating
- Two-year Premium Scratch Coatings
- Polycarbonate lens material
- Anti-reflective coatings
- Photochromics (transitions)

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
- Orthoptics or vision training, subnormal vision aids, or non-prescription lenses
- Replacement of lenses or frames furnished under this Plan which are lost or broken unless you are eligible for lenses or frames at replacement date
- Two pairs of glasses in lieu of bifocals
- Any eye exam required by an employer as a condition of employment; or any services or materials provided by any other vision care plan or group benefit plan containing vision care benefits

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.

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 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.

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 or participation agreement. You must have benefit level P1 or C2 to be eligible for laser eye surgery benefits. Levels P3 and P4 are not eligible for Laser Eye Surgery benefits.
Eligible Dependents	This is a member-only benefit. Dependents are not eligible for this benefit.
When Your Coverage Begins	If you are a Parent Body or C-branch member, you must be eligible for benefit level P1 (except through the buy-up option) or C2, as applicable, for a minimum of 12 consecutive months before your coverage begins.
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.
When Your Coverage Ends	You will no longer be eligible for 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 1-800-233-2043.

The Laser Eye Surgery Plan

What the Fund Pays

The Fund pays 80% of the cost of medically appropriate laser eye 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

To file a claim, you must forward a bill or other provider claim form that includes the following:

- The provider name, address, and taxpayer ID number
- 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 19034-3257

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.

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 or participation agreement. You must have benefit level P1 or C2 to be eligible for Hearing Aid benefits. Levels P3 and P4 are not eligible for Hearing Aid benefits.
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 work period, you will be eligible to participate in the corresponding benefit/eligibility period.
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.
When Your Coverage Ends	You will no longer be eligible for 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 1-800-233-2043.

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, but not to exceed the actual charge.

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

To file a claim, you must forward a bill or other provider claim form that includes the following:

- The provider name, address, and taxpayer ID number
- 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 19034-3257

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* Insurance Company. 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 or participation agreement. You must have benefit level P1 or C2 to be eligible for Dental benefits. You must be eligible for P1 or C2 benefits for 12 consecutive months to be eligible for the Dental Implant benefit. Levels P3 and P4 are not eligible for Dental benefits.
Eligible Dependents	Your eligible dependents include your spouse and children under age 26.
When Your Coverage Begins	After your employer has made the minimum required contribution in a work period, you will be eligible to participate in the corresponding benefit/eligibility period.
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.
Dental Implants	You may see any dental provider of your choice. Fidelio will pay up to $1,500 per implant to a maximum lifetime benefit of $3,000
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 for 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 1-800-233-2043.

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. Please note that participants may opt-out of dental benefits if they so choose.

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 $1,500 per person per calendar year. In addition, *Fidelio* pays 80% (no deductible) for orthodontia services for children up to 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 plus any amount that exceeds the maximum benefit of $1,500 per calendar year.

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 $1,500 per person per calendar year annual maximum benefit for all preventive and diagnostic, basic and restorative, and major services, for treatment received from both participating and non-participating providers combined. In addition, *Fidelio* pays 50% (no deductible) for orthodontia services for children under age 19 with a lifetime maximum benefit of $1,000.

Again, the lifetime maximum orthodontia benefit applies to treatment received from both participating and non-participating providers combined.

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 coverable 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 and family dental expenses, 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 (including 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 $1,500 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.

Dental Implant Benefit

The Fund offers a dental implant benefit for you and your eligible dependents as long as you are eligible for P1 or C2 benefits for the 12 consecutive month period immediately preceding the date of service. If you are not eligible for P1 or C2 benefits for each of the 12 months prior to your date of service, you will not be eligible for the dental implant benefit.

You are free to use any dental provider for this dental benefit, there is no preferred network. *Fidelio* will pay up to $1,500 per person for medically appropriate dental implants. The maximum lifetime benefit is $3,000 per person. This maximum is applied to the combination of in- and out-of-network services received.

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	$1,500 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
Dental Implants		
	Up to $1,500 per implant; up to $3,000 per lifetime This benefit is in addition to your calendar year maximum for other covered dental services	

**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 $300 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 Implants

Fidelio will pay up to $1,500 per person for medically appropriate dental implants. The maximum lifetime benefit is $3,000 per person. This maximum is applied to the combination of in- and out-of-network services received.

Dental implants are composed of three parts:

- Implant Body: the portion that is screwed into the jaw bone
- Abutment: the piece that is screwed into the implant body
- Implant Crown: the crown/cap that is seated or glued onto the abutment

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 coverable 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 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 are coverable 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 Mount Carmel Avenue
Glenside, PA 19038-2245

Remember that you must ask your dentist to send a claim form to "pre-determine benefits" if your expenses are expected to exceed $300.

Claims must be filed within 90 days of the date treatment is received. Claims received after 90 days will not be considered for payment.

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.

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 or participation agreement. You must have benefit level P1 or C2 for the Prescription Drug benefit. Benefit levels P3 and P4 are eligible for the ESI discount card only.
Eligible Dependents	Your eligible dependents include your spouse and children under age 26.
When Your Coverage Begins	After your employer has made the minimum required contribution in a work period, you will be eligible to participate in the corresponding benefit/eligibility period.
Cost	Your employer makes contributions to the Welfare Fund on your behalf.
Prescription Drug Plan for Benefit Levels P1 and C2	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.
Prescription Drug Discount Card for Benefit Levels P3 and P4	You receive an ESI discount card for discounted rates on prescriptions at participating pharmacies.
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 for 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 1-866-294-1558 or visit www.express-scripts.com. ▪ For questions about eligibility, call the Fund office at 1-800-233-2043.

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 1-866-294-1558, or visit their Website at www.express-scripts.com. You will need the member's social security number or the ESI identification number (found on your ESI ID card) in order to access information. You can also go to www.express-scripts.com and click on "Express Scripts Mobile" to download the ESI mobile app for your smart phone.

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 (and any additional cost, see "If you Use a Brand Name Drug that Has a Generic Equivalent") 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 your initial fill and one refill, 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 "If you Use a Brand name Drug that Has a Generic Equivalent" 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 generally expected to take for six months or more), you may obtain a one-month supply plus one refill 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 for up to a 34 day supply 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 Package 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 generally 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 Website 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. 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 Website 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 (or "non-formulary").

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*

*There may be supply limitations on some medications

Under the provisions of the Patient Protection and Affordable Care Act (PPACA), the maximum amount you pay (maximum out-of-pocket) for in-network eligible prescription drugs is limited. Once the copayments you pay for covered expenses reach your out-of-pocket maximum amount, the Fund covers 100% of your eligible expenses. In 2015 your maximum out of pocket expense is $4,600 per person/$9,200 per family. This amount is subject to change annually based on Federal guidelines.

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. If approved by the Fund, your reimbursement will be based off of the contracted amount.

Utilization Management

The Fund has several programs in place that use a stepwise approach to manage drug utilization and drug spend. These programs are designed to guide patients to safer, more cost-effective drug choices using clinically based criteria designed to ensure that each choice reflects the right *patient*, right *drug*, and right *amount.*

Prior Authorization: Certain covered drugs that have been approved by the U.S. Food and Drug Administration (FDA) for specific medical conditions require prior authorization. This program applies evidence-based criteria to ensure that patients use the medication that is clinically appropriate for their condition.

Step Therapy: This program encourages patients to use clinically effective, front-line medications before using second-line medications. With Step Therapy, prescriptions are filled with an effective but more affordable medication (Step 1). When clinically necessary, a more costly (Step 2) medication can be approved if the Step 1 prescription is not effective in treating the condition.

Drug Quantity Management: This program promotes appropriate dispensing by aligning quantities with FDA-approved dosage guidelines and other medical evidence.

Because utilization management programs are continually reviewed and updated by ExpressScripts, you (or your prescribing physician) can always call the toll-free number on the back of your prescription drug ID card for additional information or with any questions you may have.

Specialty Drugs

If you require a specialty medication, you must use Express Scripts specialty pharmacies.

Accredo, the specialty pharmacy of Express Scripts, provides **personalized care and access to medication** for patients with chronic, often serious health conditions requiring certain types of injectable, infused, oral and inhaled drugs. Part of their mission is to ensure that you get all the training, education, and support you need to administer specialty medications and stick to your prescribed therapy plan.

Specialty patients receive:

- Patient education materials
- Medication with supply kits that contain all the supplies to administer their therapy
- Access to an on-call pharmacist, 24 hours a day

Accredo provides every patient starting on a therapy with a Welcome Packet. This packet provides patients with Accredo service along with the appropriate contact numbers to access their clinical staff and patient care coordinators.

Accredo offers specialized pharmacy care for patients diagnosed with chronic illnesses like:

- Cancer
- Growth Hormone Deficiency
- Hemophilia & other bleeding disorders
- Hepatitis C
- HIV/AIDS
- Multiple Sclerosis
- Psoriasis
- Pulmonary Arterial Hypertension
- Pulmonary Fibrosis
- Rheumatoid Arthritis

The Express Scripts Discount Card

Benefit Levels P3 and P4 receive an ESI discount identification card. Although the Fund does not provide any reimbursement for prescriptions that you have filled, you do share in the discounts that the Fund negotiates through Express Scripts when you use your ESI discount card at a participating pharmacy.

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
- Contraceptives
- Any drugs required to be covered as the result of Federal legislation

Prescription Drug Charges Not Covered

Some prescription drugs and supplies are not covered under the plan. For example, the plan does not cover:

- Over the counter (OTC) and OTC equivalents that may be prescribed by a physician but can be purchased without a prescription, unless coverage is required through Federal legislation
- Prescription drugs when there is an over the counter (OTC) equivalent
- Fertility drugs
- Impotence medications
- Drugs prescribed or indicated for cosmetic purposes
- Artificial appliances, therapeutic devices, or similar devices
- Drugs prescribed by anyone other than a practitioner licensed to prescribe
- Prescriptions dispensed and verified 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 prescription drug, treatment, supply, device or service covered under the Medical plan
- 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. If approved by the Fund, your reimbursement will be based off of the contracted amount, which may be less than your out of pocket expense.

Note: If you choose a brand name drug that has a generic equivalent, the amount that Express Scripts 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 as 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 Allied Trades Assistance Program (ATAP).

Eligibility	You may be eligible if your employer is making contributions to the Welfare Fund as the result of a collective bargaining or participation agreement. All Benefit Levels are eligible for the EAP. Benefit Levels P1 and C2 are eligible for inpatient and outpatient Mental Health and Substance Abuse benefits. Benefit Level P3 is eligible only for inpatient Mental Health and Substance Abuse benefits, including inpatient physician charges. Benefit Level P4 is eligible for the inpatient hospital charge only.
Eligible Dependents	Your eligible dependents include your spouse and children under age 26.
When Your Coverage Begins	After your employer has made the minimum required contribution in a work period, you will be eligible to participate in the corresponding benefit/eligibility period.
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, and 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 five visits with a counselor each calendar year.
How Mental Health and Substance Abuse Benefits Work	ATAP 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 ATAP's network of providers, you'll save money. If you don't have a provider, ATAP can help you find one. Before you begin treatment, whether you use a participating provider or not, you must call ATAP to pre-certify treatment or benefits will not be paid.
Claim Submission	Your ATAP 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 for 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 1-800-258-6376. ▪ For questions about eligibility, call the Fund office at 1-800-233-2043.

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 the Allied Trades Assistance Program (ATAP).

As a Fund member, both you and your eligible dependents may use these services at any time. If you are eligible for welfare benefits, coverage for the EAP is automatic; there is no need to enroll.

How the EAP Works

ATAP provides a toll-free access to information, intervention, and triage 24 hours a day with a trained counselor. When you call a trained counselor, they will take as much time as you need and work with you to assess the situation. They will complete an initial intake assessment to identify problematic concerns for urgency, depth and breadth of issues and determine whether the concerns can be effectively resolved with the brief and solution-focused services at ATAP. If appropriate, they will schedule a face-to-face session with a professional counselor.

ATAP offers face-to-face solution-focused counseling. This model of assistance has been proven to save health care costs and provide a solution for dealing with life's challenges as they arise. The Fund pays the full cost for up to 5 sessions each calendar year. ATAP counselors will provide crisis intervention, assessment and solution-focused counseling sessions with referrals for longer-term care to community resources, support groups or professional counseling services as appropriate.

To contact the EAP, call 1-800-258-6376.
Help is available 24 hours a day, 365 days a year.

ATAP Counselors and Confidentiality

The staff at ATAP is directly responsible for the specific needs of Union members, their dependents and retirees; providing them with personal, confidential and appropriate referral and follow up services. ATAP counselors include certified employee assistance professionals, certified addictions counselors, licensed psychologists, licensed social workers, and certified marriage and family counselors.

All contacts with the EAP are 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 five face-to-face sessions per calendar year with a qualified ATAP participating provider for a wide range of personal issues and concerns, including but not limited to:

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		

Speak confidentially with an ATAP counselor 24/7 by calling 1-800-258-6376 or 215-677-8820 to address the next steps needed to resolve your daily living concerns.

Trauma or Critical Incidents

With the increased threat and incidences of traumatic events in the workplace, it is critical that organizations develop a plan for crisis intervention and support. ATAP has put together a team of crisis experts that are able to advise and debrief on critical incidents including: traumatic accidents, violence, fatalities, national disasters, etc.

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 available through ATAP. If you've contacted the EAP and further treatment is clinically appropriate, an ATAP counselor will assist you to locate an in-network provider that best meets your clinical needs**.**

How ATAP Works

ATAP has carefully selected a wide variety of treatment providers for inclusion in the preferred ATAP network. The selection of these providers is based on the following criteria: quality of services, cost of services, and geographic proximity to member. ATAP has selected providers offering the following levels of care: medical detox, non-medical detox, inpatient psychiatric rehab, freestanding rehab, intensive outpatient treatment, outpatient counseling, outpatient psychiatric services and aftercare groups.

When you need assistance selecting an in-network provider, contact ATAP. A qualified counselor will work with you to select a provider that best meets your clinical needs. You may also choose a provider that does not participate in the preferred ATAP network (called out-of-network). Generally, your out of pocket expenses are *significantly* lower if 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 ATAP or benefits will not be paid. To pre-certify treatment, call 1-800-258-6376.

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 ATAP to pre-certify your treatment. ATAP will determine the level of care that is needed and, if you don't already have one, ATAP will assist you in finding a provider. ATAP 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

ATAP 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 ATAP 24 hours a day, seven days a week, or you can call the provider directly.

To find an in-network provider near you, call ATAP at 1-800-258-6376 or go to ATAP's website: http://alliedtrades-online.com

Changing Providers

When you call ATAP, they will make every attempt to select an in-network provider who will best meet your clinical needs. If you are dissatisfied with the in-network provider you've seen, call ATAP at 1-800-258-6376. 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 a participant in the preferred ATAP network, you may continue to see that provider. However, you must pre-certify treatment. When opting to utilize an out-of-network service provider, your benefits will be lower and you will be subject to more out of pocket expense.

Sharing the Cost of Services

While the Fund 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 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 care before the program pays benefits for those services. Your annual deductible is $300 per person/$600 per family.

Usual, Customary, and Reasonable (UCR)

The usual, customary, and reasonable (UCR) amount is the amount that ATAP considers a fair or typical charge for the service in your area. If you use non-network 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 ATAP network or any other qualified provider. The Fund pays a larger share of your expenses when you receive care from an ATAP preferred in-network provider.

Plan Feature	In-Network Care	Out-of-Network Care[1]
Annual Deductible	$0	$300 per person/$600 per family
Out of Pocket Maximum[2]	$2,000 per person/$4,000 per family	$3,000 per person/$6,000 per family
Lifetime Maximum	Unlimited	Unlimited
Office visit—specialist	100% after $10 copay/visit	70% of UCR after deductible
Inpatient[3]	100% after $75 copay per day (up to $375 maximum per admission)	70% of UCR after deductible
Inpatient Hospital Days	365	70

[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]Your Out-of-Pocket maximum includes expense incurred under the Medical Plan

[3]Copayment waived if re-admitted within 10 days of discharge

It's Confidential

All contacts with ATAP are confidential—all records are treated confidentially. No information can be released outside of ATAP without your written consent, and no one at the Fund office will have access to information about your personal circumstances.

Filing Claims

In-Network Claims

If you use an in-network provider, you do not file claims. ATAP 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.

To file a claim, have your provider complete the standard HCFA claim form. Then, send the completed claim form and the original provider bill to ATAP. The bill should include:

- The provider name, address and Tax ID number
- Date of service
- Patient name and Date of Birth
- Type of service and charges
- Diagnosis
- The member's name and Social Security number

Send claims to:

Allied Trades Assistance Program—Care of Claims Department
4170 Woodhaven Road
Philadelphia, PA 19154
Phone: 267-351-4086

If you have already paid the bill, include a paid receipt so that any payment can 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 ATAP 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.

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 or participation agreement. You must have benefit level P1 or C2 to be eligible for Disability benefits. Levels P3 and P4 are not eligible for Disability benefits.
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 work period, you will be eligible to participate in the corresponding benefit/eligibility period.
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 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., D.O., or D.P.M. in the continental United States.
When Benefits Begin	Your weekly disability benefits will begin on the following: ▪ First day after you come under the professional care of your M.D., D.O., or D.P.M for a 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., D.O., or D.P.M. for an illness
How Long Benefits Are Paid	You may receive weekly disability benefits for up to 52 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 $350 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 for the disability plan if 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 1-800-233-2043.

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 after you first come under the professional care of an M.D., D.O., or D.P.M. for a 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., D.O., or D.P.M. 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., D.O., or D.P.M. within the continental limits of the United States. Totally disabled means you are unable to perform the duties required by your job as evidenced by medical records that may be required from your physician.

Amount of Benefits

Weekly disability benefits can provide you with $350 per week (or $50.00 per day if your disability lasts less than a week). This benefit is secondary to any disability payment provided by your employer. If your employer provides a benefit of $350 or more per week, your Fund benefit would be $0. If your employer's disability payment is less than $350 per week, your Fund benefit would be the difference between the benefit payable by the Fund and the benefit provided by your employer.

About Taxes

FICA and State Unemployment Taxes are required to be withheld from your disability payment.

How Long Benefits Continue

As long as you remain disabled, you may receive weekly disability benefits for up to 52 weeks for:

- Any one period of disability; or,
- 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., D.O., or D.P.M. within the United States. If the sickness or injury is work-related, you must apply for workers' compensation benefits through your employer instead. You must apply for disability benefits within 90 days of the date of your claim for disability or claims will not be considered for payment.

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., D.O., or D.P.M.

If you return to full-time, active work for at least 80 hours your 52-week disability benefit period renews, regardless of whether it is a continuation of your prior disability diagnosis.

Example

Assume you file a claim for February 1, 2016 and you collect 40 weekly disability payments as a result of a disability. You then return to active, full time work from October 1 to November 1, and you work a minimum of 80 hours. If you file a claim for disability benefits prior to February 1, 2017, assuming you are eligible, your 52-week disability benefit period would renew with the date of disability. You would not need to wait until February 1, 2017 for your 52-week benefit period to renew.

Assume instead that you file a claim for February 1 and you collect 52 consecutive weekly disability payments. You would not become eligible for another 52 weeks of disability coverage, even if the disability is a continuation of your prior claim, until you return to work for at least 80 hours and you meet other eligibility criteria.

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., D.O, or D.P.M. within the United States
- For period during which you are collecting state unemployment benefits
- If you become disabled during a period when you are not eligible for a weekly disability benefit from the Fund
- When information provided by your physician is insufficient to support a claim of disability

Filing Claims

Call the Fund office at 1-800-233-2043 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. The Fund will advise you on when your attending physician must complete and return a new form. Note that when required, a form must be completed and signed by the physician—not only 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.

Death and Accident

Additional information on Death and Accident Benefits can be found in the Pension Plan Summary Plan Description (Pension SPD)

Generally, the death, accidental death, and dismemberments are paid by the Pension Fund. If you work in covered employment for a contributing employer who makes contributions to the Welfare Fund but not to the Pension Fund, you may still be eligible for benefits. The death, accidental death, and dismemberment benefits are administered by the Standard Insurance Company. 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 or Pension Fund as the result of a collective bargaining or participation agreement. This is a member only benefit. No benefits are payable upon the death or dismemberment of your dependents.	
Cost	Your employer makes contributions to the 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 (Parent Body)	A benefit may be paid to your beneficiary if: ▪ You are vested under the IUOE Local 542 Pension Fund and were credited with at least 500 hours in the 24 months prior to your death; or ▪ You are not vested under the IUOE Local 542 Pension Fund, but you were credited with at least 1,000 hours in the 24 months prior to your death.	A benefit may be paid to your beneficiary if you were eligible for death benefit 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 and you were eligible for death benefit coverage on the day of your accident.
When Benefits Are Paid (C-branch)	A benefit may be paid to your beneficiary if: ▪ You are eligible for Welfare Fund benefits in 6 of the 12 months immediately preceding your death; and ▪ You are eligible for Welfare Fund benefits on the day you died.	A benefit may be paid to your beneficiary if you were eligible for death benefit 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 and you were eligible for death benefit coverage on the day of your accident.
Benefit Amount	The death benefit provides your beneficiary with a benefit equal to $5,000. If you name multiple beneficiaries, the total benefit payable will not exceed $5,000.	If your death is deemed accidental, the accidental death and dismemberment benefits provide your beneficiary with a benefit equal to $5,000. If you are seriously injured in a covered accident, you may receive $5,000 or $10,000, depending on the bodily losses you incur.
Claim Submission	To start the claim process, your beneficiary should notify the Fund office. The Fund will provide necessary claim forms to your beneficiary and upon receipt of required documentation, forward to Standard for processing.	To start the claim process, you or your beneficiary should notify the Fund office. The Fund will provide necessary claim forms to your or your beneficiary and upon receipt of required documentation forward to Standard for processing.
When Your Coverage Ends	You will no longer be eligible for these benefits if you fail to meet any applicable Plan requirements.	
Questions	Call the Fund office at 1-800-233-2043.	

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. If you name multiple beneficiaries, the total benefit payable will not exceed $5,000.

When Benefits Are Paid

If you die, a benefit may be paid to your beneficiary.

If you are a Parent Body member, your beneficiary will receive a benefit if:

- You are vested under the IUOE Local 542 Pension Fund and you were credited with at least 500 hours in the 24 months prior to your death; or
- You are not vested under the IUOE Local 542 Pension Fund, but you were credited with at least 1,000 hours in the 24 months prior to your death.

If you are a C-branch member, your beneficiary will receive a benefit if:

- You are eligible for Welfare benefits in 6 of the 12 months immediately preceding your death; and
- You are eligible for Welfare benefits on the day you died

Naming Your Beneficiary

You elect a beneficiary by completing a Beneficiary Form. If you name more than one beneficiary, you may specify different amounts to be paid to each, but the total payable may not exceed $5,000. If you do not specify different amounts, your beneficiaries will receive equal shares. Spousal beneficiary designation is nullified in the event of a divorce. If you and your spouse divorce, and you named your spouse as your beneficiary, you must contact the Fund office to complete an updated beneficiary form. Note that you may still designate your ex-spouse as your beneficiary, but only by completing a new beneficiary form and designating your ex-spouse as your beneficiary.

You can change your beneficiary at any time by completing a 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. If you name multiple beneficiaries, the total benefit payable will not exceed $5,000. If your beneficiary survives you, but dies prior to payment being made, payment shall be made to the beneficiary's estate.

Death benefits will not be payable to any named beneficiary who has been adjudicated legally responsible for your death.

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. Note that, while you or any authorized individual may call the Fund Office to request information, the response from the Fund Office will ONLY be provided in writing to the member address on file (or the address of your authorized representative).

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 (e.g., one foot and one hand)	$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

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 you were eligible for death benefit coverage on the day you died, your death is deemed accidental, as indicated on the death certificate, and your death 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. Eligibility requirements are the same as the requirements for death benefits.

“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 or injury
- Acts of terrorism

Filing Claims

If you die, your beneficiary should notify the Fund office promptly. The Fund office will send your beneficiary a Death Claim Form and, once returned, the Fund office will forward the claim for benefits to Standard. Your beneficiary should send:

- Completed and signed Death Claim Form. If there is more than one beneficiary, every beneficiary may be required to complete a form that includes their name, address, date of birth, and Social Security number
- Certified (original) copy of your official death certificate

Claims will be processed by Standard as soon as administratively practicable.

Death benefits will not be payable to any named beneficiary who has been adjudicated legally responsible for your death.

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 as an employee 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 you are covered as a dependent under this plan and as a dependent under a spouse's plan, the spouse's plan pays first and this plan is secondary. 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, 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. You must notify the Fund office with information about any other group health insurance plan under which you or any of your dependents are eligible. Failure to provide this information may result in a denial of a claim for benefits.

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

The purpose of this Section is to insure that the limited funds available to finance the benefits provided by the Fund are not used to provide benefits where other funds may be available to pay the cost of the benefits provided by the Fund. Covered Persons are required to comply with the Fund's procedures for third-party liability claims (including subrogation). The Fund will not pay related claims should a Covered Person fail to comply with those procedures. In furtherance of this purpose, in the event that the Fund has made, does make or is obligated to make payments to or on behalf of a Covered Person arising out of any Illness or Injury then, as a condition for receiving benefits from the Fund, the Covered Person shall:

(1) Notify the Fund, in writing, that a Claim relating to such Illness or Injury has been filed by the Covered Person against a third party seeking Available Funds,

(2) Notify the Fund, in writing, of the name and address of the Covered Person's attorney, provide the attorney with a copy of this Section and any Subrogation/Reimbursement Agreement ("Agreement") the Fund may require the Covered Person to sign in order to receive benefits and require that the attorney comply with the terms of this Section and of any such Agreement. The Fund may require the attorney to agree, in writing, to comply with the terms of this Section and of any such Agreement.

(3) Keep the Fund 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 Fund to or on behalf of the Covered Person and/or claimed from the Fund by or on behalf of the Covered Person.

(5) Specifically grant the Fund a first right of reimbursement and reimburse the Fund that portion of the Available Funds which is due to the Plan for benefits paid to or on behalf of the Covered Person as well as for any premiums and other payments paid on behalf of the Covered Person to continue health insurance and/or other coverage pursuant to any Disability Eligibility Credit provisions of the Fund. The right of reimbursement granted to the Fund by the Covered Person includes the right of the Fund to seek reimbursement from any person or entity that holds the Available Funds, including but not limited to, a legal guardian, representative, trustee, parent or Dependent.

(6) Specifically grant to the Fund subrogation and all rights of recovery and causes of action that the Covered Person may have against the third-party, whether by suit, settlement or otherwise, that may be liable for the Covered Person's Illness or Injury for which the Fund has paid or is obligated to pay benefits on the Covered Person's behalf.

(7) Hold in trust for the Fund's benefit that portion of the total recovery from any source that is due for payments made or to be made. The Covered Person shall reimburse the Fund immediately upon recovery. The Participant, and any other person who holds (or who has any title to) the Available Funds, shall be considered an ERISA fiduciary with respect thereto and may not assign, transfer, pledge, encumber, alienate, spend, or dispose of, the Available Funds.

(8) Do nothing to impair, release, discharge or prejudice the Fund's rights to subrogation and/or reimbursement. The Covered Person shall assist and cooperate with representatives the Fund designates. The Covered Person shall do everything necessary to enable the Fund to enforce its subrogation and reimbursement rights.

(9) Require and authorize Covered Person's attorney, if any, to withhold from Available Funds any monies due the Fund pursuant to this Section and/or the Agreement and to forward them to the Fund as required by this Section and/or the Agreement. In case of any dispute over what monies are due the Fund, Available Funds shall be escrowed pending resolution of such dispute.

(10) Future Benefits. The Fund will not pay for any future medical services arising from and/or related to the Illness or Injury unless a mutually agreed-upon amount of the Available Funds are set-aside for the payment for such services. Further, in accordance with the Fund's "Erroneous Payments" provision, should a Participant fail to comply with the provisions of this Agreement, the Trustees of the Fund may take any reasonable action to recoup the benefit paid hereunder (together with interest and, where applicable, costs) including, without limitation, by offsetting future benefits and/or payments.

Counsel Fees. The Fund shall have no obligation to pay any attorney's fees to any attorney retained by the Covered Person to pursue Third Party Claims or to have any attorney's fees or costs withheld from amounts due to the Fund. The Fund shall not be bound by any agreement to the contrary made by the Covered Person. The Covered Person shall be solely responsible for paying all legal fees and expenses in connection with any recovery and the Fund's recovery shall not be reduced by such legal fees or expenses unless the Fund Administrator, in his sole discretion, agrees in writing to discount the Fund's claim.

Right to set-off. The Covered Person agrees that in the event that the Covered Person fails or refuses to comply with the provisions of this Section and/or the Agreement, then the Fund, in addition to any other rights to which the Fund or the Trustees thereof might have, shall have the right to withhold from any payments due or which become due to the Covered Person or to third parties on behalf of the Covered Person any amounts necessary until the Fund is fully reimbursed as described in this Section and/or the Agreement.

Recording or use. The Covered Person hereby authorizes the Fund to record and/or use this Section and/or the Agreement in any proceedings involving the Covered Person including using this Section and/or the Agreement in any Third Party Claims that the Covered Person may have.

Authorization to pay. The Covered Person hereby authorizes any person or entity paying Available Funds to or on behalf of this Covered Person to pay over to the Fund such monies as the Fund is entitled to under this Section and/or the Agreement and this Section and/or the Agreement shall constitute their warrant to do so. In case of any dispute over what monies are due the Fund, Available Funds shall be escrowed pending resolution of such dispute.

Minors. Any Covered Person making a Claim on behalf of any minor child under the Fund's plan of benefits shall make the Agreement on behalf of said minor child and agrees that he/she is authorized to make the Agreement on behalf of said minor child.

Other Insurance. It is agreed that any payment received by a Covered Person from any insurance carrier, from Blue Cross, from Blue Shield or from any like or similar plan for which the Covered Person has paid the full premium in order to secure individual, as distinguished from group coverage, shall be excluded from the requirements of this Section and/or the Agreement. It is agreed that benefits payable under the Fund will be secondary to benefits provided or required by workers' compensation, or any group or individual automobile, homeowner's or premises insurance, including medical payments, personal injury protection, or no-fault coverage, regardless of any provision to the contrary in any other policy of insurance.

Rejection of make-whole doctrine. The application of the make-whole doctrine is specifically disavowed by the Fund and by the Covered Person. The Covered Person agrees that the Fund's right to reimbursement, as set forth above, takes first priority on a first-dollar basis over any other claims, regardless of whether or not Covered Person has been fully compensated for all claims for damages or whether the Available Funds include payment for medical or non-medical expenses or are so characterized.

Equitable Lien/Constructive Trust. By making payments on behalf of the Covered Person, the Fund is granted an equitable lien by agreement and constructive trust over the Available Funds, to which the Covered Person consents.

Rejection of Common Plan doctrines. Covered Person agrees to the Fund's express rejection of Common Plan doctrines. The Fund's reimbursement and subrogation rights apply to any recovery by a Covered Person without regard to legal fees and expenses of the Covered Person.

For purposes of this Section, the following terms shall be defined as follows:

(1) The term **"Covered Person"** shall have the same meaning as in the "Definitions" Section of this Summary Plan Description and shall also include any Dependent and/or beneficiary of any Covered Person who may be entitled to benefits under the terms of the plan of benefits, as well as any parent(s), heir(s), estate(s), trust(s), guardian(s), representative(s) and any other person or entity that may be entitled to or that may receive a benefit from the Fund.

(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 work of the Covered Person.

(3) The term **"Available Funds"** shall mean monies recovered from third parties through a lawsuit, settlement or otherwise (whether called pain and suffering, weekly indemnity, workers compensation, damages, restitution, wage loss, medical reimbursement, out of pocket expenses or any other term) as a result of the injury or illness. Available Funds shall be considered plan assets under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") (without regard to how, or with respect to whom, such Available Funds are held or titled).

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

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.

Erroneous Payments

Notwithstanding any other provision of the Plan to the contrary, any person who receives a benefit (including a payment) under the Plan shall be required to repay to the Plan: (1) any erroneous payment made to or on behalf of such person, including the value of any benefit erroneously provided, whether due to administrative mistake or otherwise; (2) appropriate interest; and (3) in the case of fraud or misrepresentation or in the event repayment is contested, any and all costs of collection (including attorney's fees). In addition, the Trustees may take any reasonable action to recoup such erroneous payment or benefit, together with interest, and where applicable, costs, and including, without limitation, by offsetting future benefits and/or payments.

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 (and any dependents eligible for coverage under the plan) 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 Health and Welfare Plan. Each participant is individually responsible to make their own private arrangements through their automobile insurance company to obtain hospital, medical, and prescription drug 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.

Plan Operation and Rights

Introduction

This section covers the administration and funding of the Welfare plans, as well as your rights under the following 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 protected health information (called “PHI”)
- The Patient Protection and Affordable Care Act of 2010 (PPACA)—which expands the categories of benefits that must be offered under qualified health plans, and the dependents to whom coverage must be offered

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 Welfare Fund of Eastern Pennsylvania and Delaware

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
Chris Lodge
Charles Priscopo

Mailing Address
Suite 100
1375 Virginia Drive
Fort Washington, PA 19034-3257

Employer Trustees

James Davis
Michael J. Driscoll, Jr.
Francis Pietrini

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 or participation agreements with the Union. The agreements require contributions to the Fund at fixed rates.

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
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	***Allied Trades Assistance Program (ATAP)*** 4170 Woodhaven Road Philadelphia, PA 19154	Benefits are provided through a self-funded program that is financed with employer contributions
Dental – Preferred Provider Organization (PPO) – Dental Implants	***Fidelio Insurance Company*** 2826 Mt. Carmel Avenue Glenside, PA 19038-2245	Benefits are provided through an insurance contract Benefits are provided through a self-funded program that is financed with employer contributions
Vision	***Vision Benefits of America (VBA)*** 300 Weyman Plaza Suite 400 Pittsburgh, PA 15236-1588	Benefits are provided through a self-funded program that is financed with employer contributions
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
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	***Standard Insurance Company*** PO Box 3789 Portland, OR 97228-3789	Benefits are provided through an insurance contract.

**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 self-insured 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, 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 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 claim or plan 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 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 medical claims only the notice will also:
  - be provided in a culturally and linguistically appropriate manner (non-English language provided if 10% or more of the residents of your county of residence are literate only in the same non-English language)
  - furnish information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable)
  - describe the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning
  - include the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim
  - disclose the availability of and contact information for any applicable office or health insurance consumer assistance or ombudsman, if any, established by the Department of Health and Human Services to assist with the internal claims and appeals and external review processes
  - describe the available appeals and external review processes
  - 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 rescission of coverage under a medical plan will be considered an adverse benefit determination and you will be able to appeal the rescission under these procedures. A rescission is a discontinuance of coverage with retroactive effect. Coverage may be rescinded if an individual or person seeking coverage on behalf of the individual commits fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan. However, a retroactive cancellation of coverage is not considered to be a rescission if it is due to failure to pay required premiums or contributions toward the cost of coverage on time. If your coverage is going to be rescinded, you will receive written notice at least 30 days before the coverage will be cancelled.

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, we will provide you with the names of each such expert, regardless of whether the advice was relied upon.

If any new or additional evidence is considered, relied upon, or generated by the plan or an issuer (or at the direction of the plan or an issuer) in connection with your claim, you will be provided free of charge with such evidence as soon as possible and sufficiently in advance of the date of which the notice of final internal adverse benefit determination is required to be provided to you as specified in the Claims Review Chart above. If new or additional rationale is relied upon in denying your claim on review, you will be provided with the new or additional rationale as soon as possible and with enough time before a final determination is required to be provided to you so that you will have a reasonable opportunity to respond. You may also review the claim file and present evidence and testimony.

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, guidelines, 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."
- For medical claims only the notice will also include, in a culturally and linguistically appropriate manner:
  - Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable))
  - the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim, including a discussion of the decision

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.

External Review Process

If, upon review, your claim for medical benefits is still denied or deemed to be denied, you may be able to submit your claim to the external review process described below. However, if your medical benefits are provided by an insurance company subject to a state external review process that satisfies the requirements of section 2719 of the Public Health Service Act, the state external review process will apply to your external review rights. The external review process described below is only available to you if your claim resulted in an adverse benefit determination that involves medical judgment (including, but not limited to, medical necessity, appropriateness of care, health care setting, level of care, effectiveness of a covered benefit, or a determination as to whether a treatment or procedure is experimental or investigational) or involved a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Effective January 1, 2012, if the claims administrator fails to adhere, except for de minimis violations, to all of the time frames and requirements for processing claims as described above, then you are deemed to have exhausted the internal claims and appeals process and may initiate this external review process, if applicable, or pursue any other remedies available to you, including filing suit, under ERISA section 502(a). A violation is considered de minimis if it was non-prejudicial, attributable to good cause, or due to matters beyond the control of the claims administrator, occurred in the context of an ongoing, good faith exchange of information between you and the claims administrator, and is not reflective of a pattern or practice of non-compliance. You may request a written explanation of the violation from the claims administrator, and such explanation must be provided within 10 days, including a specific description of the basis, if any, for asserting that the violation is de minimis.

Within four months of the date you receive notice that, upon review, your claim continues to be denied, you may submit your written request for an external review to the claims administrator. Your written request may include issues, comments, documents, records, or other information relating to your claim that you want considered in reviewing your claim.

Unless you request an expedited external review, your review will be processed as a standard external review.

You can request an expedited external review under the following circumstances:

- You filed a request for an urgent care appeal and the time frame for completion of the appeal would seriously jeopardize your life, health, or your ability to regain maximum function.
- You received an adverse final determination and the time frame for completion of the standard external review would seriously jeopardize your life, health or your ability to regain maximum function, or the final adverse determination concerned an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Standard External Review

Preliminary Review. Within five business days after receipt of your external review request, the claims administrator must complete a preliminary review of your request to determine if your claim is eligible for external review. Your claim is eligible for external review if:

1. you are or were covered under the group health care benefit when the item or service was requested or provided,

2. your claim or appeal denial involved medical judgment or a rescission of coverage,

3. you have exhausted the internal appeal process (or you are deemed to have exhausted the internal appeal process, as described above), and

4. you have provided all information and forms required to process the external review.

Within one business day after completion of the preliminary review, your claims administrator will notify you in writing regarding whether your claim is eligible for external review. If your request was not complete, the notice will describe information or materials needed to complete the request. You will have until the end of the four-month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request. If your request is complete but not eligible for external review, the notice will include the reasons your request is ineligible and contact information for the Employee Benefits Security Administration.

Review Process. If the claims administrator determines your claim is eligible for external review, your claim will be assigned to an accredited independent review organization (IRO). The IRO will notify you that your claim is eligible for external review. The notice will also inform you that you have 10 business days following receipt of the notice to provide additional information to the IRO for it to consider.

The IRO will review all of the information and document timely received. In reaching its decision, the IRO will review your claim anew and not be bound by any decisions or conclusions reached during the internal claims and appeals process. The IRO will provide you with written notice of the final external review decision within 45 days after it receives the request for external review. The notice will contain:

- a general description of the reason for the request for external review, including sufficient information to identify the claim (date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, treatment code and its corresponding meaning, and reason for previous denial);
- the date the IRO received the assignment and the date of the IRO decision;

- references to evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or the claims administrator;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

If the adverse benefit determination or final internal adverse benefit determination is reversed, you must immediately receive coverage or payment for your claim, regardless of whether the claims administrator intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited External Review

In general, the same rules that apply to the standard external review also apply to the expedited external review, except that the time frame for decisions and notifications is shorter.

Expedited Preliminary Review. The claims administrator will immediately conduct a preliminary review of your claim and immediately notify you of its determination.

Expedited Review Process. If your claim is eligible for expedited external review, your claim will be assigned to an IRO. The IRO will notify of its final decision as expeditiously as your medical condition or circumstances require, but in no event later than 72 hours after the IRO receives the request for expedited external review. If the notice is not provided in writing, the IRO must provide you with written confirmation of its decisions within 48 hours after notice of decision is first provided to you by other means.

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 plan are coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You, your spouse, or your dependents will 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
- Elimination of exclusionary periods of coverage for preexisting conditions under your group health plan.

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 or other newly eligible dependent may also be added to the employee's COBRA coverage during the continuation coverage period but will not be considered 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 children) 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, dependent children Spouse, dependents (only)	Up to 18 months (up to 29 months if disabled at time coverage stopped or within 60 days of continuation coverage)[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
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 subsidizes the full cost of the benefit, e.g., months of continuation coverage through "buy up."

[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 dependent children 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 Advantage Plan), you or your 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 child(ren) 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., reaching limiting age)
- You and your spouse legally separate or divorce
- There is a second qualifying event:
  - If your spouse and/or dependent child(ren) (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, death, 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 (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 dependent 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 dependent 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 applicable time frame, 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 an employee/member who is covered by COBRA, you may add a new spouse or other newly eligibility dependent, 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.

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 Advantage plan), 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 (for both employee and covered dependents). 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 child 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 eligible 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 to be 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 dependent children (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 child) 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 dependent children 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 (e.g., the Plan's "buy up" option), 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. For example, assume you were "buying up" to P1 for the 5 months immediately prior to your COBRA election. If your COBRA coverage, in the absence of your P1 "buy up" was for 18 months, you would instead be offered COBRA coverage for 13 months.

When COBRA Coverage Ends

After you or your dependent children 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.
- 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 child 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.

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
- Notify affected individuals following a breach of unsecured PHI
- 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 us: (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, except if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law or the PHI pertains solely to a health care item or service for which you, or person other than the Fund on your behalf, has paid the covered entity in full.

- **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 in this SPD. 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. By law, the following types and uses and disclosures of PHI generally require your authorization: use or disclosure of psychotherapy notes, use or disclosure of PHI for marketing purposes, and disclosure of PHI for selling purposes.

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 benefit/eligibility period 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 from any qualified pension plan, 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., D.O., or D.P.M. in the United States

If you become temporarily disabled, you will be credited with hours 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. The hours with which you are credited will vary based upon the benefit level for which you were eligible, through hours worked, when you became disabled. 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 26; however, coverage may continue for mentally and physically handicapped children who are covered under the plan and handicapped at age 26, 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 divorce, etc.

A child may be covered until the day he or she reaches the limiting age (26). (See “Your Eligible Dependents”) for additional limits on dependent coverage.

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.)

Future of the Plan

While the IUOE Local 542 Welfare Fund 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 plan sponsor 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.

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 Act (ERISA).

Supplemental Unemployment Benefit (SUB)

Supplemental Unemployment Benefit (SUB) Plan Highlights

Here are some key features of the supplemental unemployment benefit plan provided through the Fund.

Eligibility	You may be eligible if you are working for an employer who is making contributions to the SUB Fund as the result of a collective bargaining or participation agreement. This is a member-only benefit.
When Your Coverage Begins	Coverage may begin after you have been credited with at least 500 hours in a 12-month period.
Cost	Your employer makes contributions to the SUB Fund on your behalf.
When Benefits Are Paid	Your supplemental unemployment benefit will be paid during periods of unemployment due to a layoff or disability. You must have been credited with at least 500 hours in the 12 months before the month of your initial benefit year. (Your initial benefit year starts on the Saturday of the week you first qualify and apply for benefits and ends 52 weeks later.)
How Long Benefits Are Paid	You may receive benefits for up to 39 weeks for either: ▪ Any one period of unemployment; or ▪ All periods of unemployment during one benefit year
Benefit Amount	The SUB Fund provides you with $125 per week.
Claim Submission	You complete the application process by phone. The SUB Application Line **(SAL)** is available to you 24 hours a day, 7 days a week. Call toll free at 1-888-542-8511. Follow the prompts to complete your initial application and your continued certification. For non-disability SUB claims, your Local District Agent must certify that you are on the Local 542 out of work list, are available for work, and have not refused employment when it has been offered.
When Your Coverage Ends	You will continue to be eligible for coverage, provided your employer continues to make the required contributions and you continue to be credited with at least 500 hours in the applicable 12-month period.
Questions	Call the Fund office at 1-800-233-2043.

The Supplemental Unemployment Benefit Plan

The Supplemental Unemployment Benefit (SUB) plan provides you with valuable and necessary income protection when you are not working because of a layoff or disability.

Who Is Eligible

To be eligible for benefits, you must be working for an employer who is making contributions to the SUB Fund as the result of a collective bargaining or participation agreement.

When You Become Eligible for Coverage

You become eligible for coverage after you have been credited with at least 500 hours in a 12-month period.

Enrolling for Coverage

You do not need to enroll; coverage is automatic.

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 or participation agreement.

When Coverage Ends

Coverage under the SUB Fund ends for you on the first day of the month your employer contributions fall below the minimum requirement.

When Benefits Begin

Benefits will begin after you apply for benefits and your application has been approved by the Fund.

You Must Be Credited with at Least 500 Hours in the Prior 12 Months

In order to qualify for benefits, you must have been credited with at least 500 hours in the 12 months before the month of your initial benefit year. For example, if your first week of unemployment ends on Saturday, March 13, you must have 500 hours in the 12-month period ending February 28.

Your initial benefit year starts on the Saturday of the week you first qualify—and apply—for benefits and ends 52 weeks later.

Your Local District Agent Must Verify Your Unemployment and Availability Status

Before your benefits may begin, your Local District Agent must certify that you:

- Are on the Local 542 out of work list
- Are available for work
- Have not refused employment when it has been offered
- Are a bona fide resident of an area within 75 miles of the geographical jurisdiction of local 542

Amount of Benefits

SUB benefits provide you with $125 per week.

How Long Benefits Continue

As long as you are unemployed, and you have at least 500 hours credited in the 12 months prior to the month of the first week of your benefit year, you may receive SUB benefits for up to 39 weeks for either:

- Any one period of unemployment OR
- All periods of unemployment during one 52 week benefit year

If Fund assets total less than $250,000 on the last day of any month, benefit payments will stop on the first day of the following month. Benefits will not resume until the first day of the following November, or until the Board of Trustees determines that there are sufficient assets.

You May Continue to Work

If you are receiving SUB benefits, you may continue to work up to 16 hours per week or two days per week, whichever is greater. **If you work more than 10 hours in any day, your SUB benefits will stop.**

If You Are Disabled

In order to collect benefits due to disability, you must be receiving either:

- Weekly disability benefits from the IUOE Local 542 Welfare Fund; or
- Workers' compensation as the result of an illness or injury incurred while you were engaged in covered employment. Covered employment means the employment of an employee for whom contributions are due by an employer who is required to make contributions to the Fund.

You must notify your local District Agent of your disability or benefits will not be paid.

To Apply for Benefits

If you are unemployed and available for work as an Operating Engineer, or if you are currently disabled, you may apply for benefits.

To apply for benefits, simply call the SUB Application Line **(SAL)** at 1-888-542-8511. You use this toll-free line to start your application. You also use the toll-free line to apply for your continued weekly benefits. You can call the toll-free number 24 hours a day, 7 days a week. Just follow the system prompts.

After your Local District Agent has verified your unemployment and availability status, your claim will be processed and a check will be mailed to you.

You must apply for benefits within 90 days of the Saturday of the week you are first unemployed and eligible for benefits. Subsequent claims must be made within 90 days of the week-ending for which benefits are payable.

To Continue Your Benefits

You use the SUB Application Line **(SAL)** to apply for continued benefits. Call 1-888-542-8511.

You may apply for multiple weeks at one time; however, you cannot apply for any week beyond the current week ending date. For example, you could call and apply on Friday, January 9th with weeks ending January 10th, January 3rd, December 27th. You could not include week ending Saturday, January 17th or beyond.

You can call the toll-free number 24 hours a day, 7 days a week. Just follow the system prompts.

If Your Application Is Denied

If you believe your claim has been improperly denied, you must appeal the denial of benefits within 180 days to the Board of Trustees.

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.

If any new or additional evidence is considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with your claim, you will be provided free of charge with such evidence as soon as possible and sufficiently in advance of the date of which the notice of final internal adverse benefit determination is required to be provided to you (45 days). If new or additional rationale is relied upon in denying your claim on review, you will be provided with the new or additional rationale as soon as possible and with enough time before a final determination is required to be provided to you so that you will have a reasonable opportunity to respond. You may also review the claim file and present evidence and testimony.

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, guidelines, 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.

Right to Recovery

If you receive benefits from the SUB Fund for which you were not entitled for any reason, the Board of Trustees has the right to recovery by withholding payment of benefits that you may be entitled to in the future until such withheld payment equals the amount incorrectly received. Or, the Board of Trustees may exercise any and every equitable right of action available for recovery of money you incorrectly received.

Other Important Information

Situations that May Result in Loss of Benefits

It is important to be aware that a loss of benefits may result from any of the following events:

- You lose your status as an eligible member
- If you willfully misuse any SUB benefits or misrepresent your eligibility, you could lose coverage for SUB Fund benefits and you will have to repay the Fund for the full amount of any benefits improperly received. The Plan Administrator will determine whether you have misused any benefits.

Right to Benefits

No person other than the Trustees of the SUB Fund shall have any right or title of interest in any of the income or property of any funds received or held for the account of the SUB Fund.

No person shall have any right to benefits provided by the SUB Fund plan except as expressly provided in this SPD.

Future of the Plan

While the IUOE Local 542 SUB Fund intends to continue the SUB plan 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 plan sponsor 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 the Board of Trustees.

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

Plan Operation and Rights

Plan Name

International Union of Operating Engineers of Eastern Pennsylvania and Delaware Supplemental Unemployment Benefit Plan.

Plan Type

The plan described in this summary plan description (SPD) is a supplemental unemployment benefit (SUB) plan.

Plan Sponsor

The plan sponsor is the Board of Trustees of the International Union of Operating Engineers of Eastern Pennsylvania and Delaware Supplemental Unemployment Benefit Fund.

Board of Trustees

The Trustees shall have the sole and absolute discretion to determine eligibility for SUB 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 plan administrator. To the extent that authority was delegated, the plan administrator has all of the power and authority of the plan sponsor.

Union Trustees

Robert T. Heenan
Thomas Danese
Chris Lodge
Charles Priscopo

Mailing Address
Suite 100
1375 Virginia Drive
Fort Washington, PA 19034-3257

Employer Trustees

James Davis
Michael J. Driscoll, Jr.
Francis Pietrini

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 plan.

The plan administrator is John Heenan.

Mailing Address

International Union of Operating Engineers of Eastern Pennsylvania and Delaware Supplemental Unemployment Benefit 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): 23-2075110.

Employer Contributions

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

International Union of Operating Engineers
1375 Virginia Drive, Suite 102
Fort Washington, PA 19034

GCC/IBT 525-M