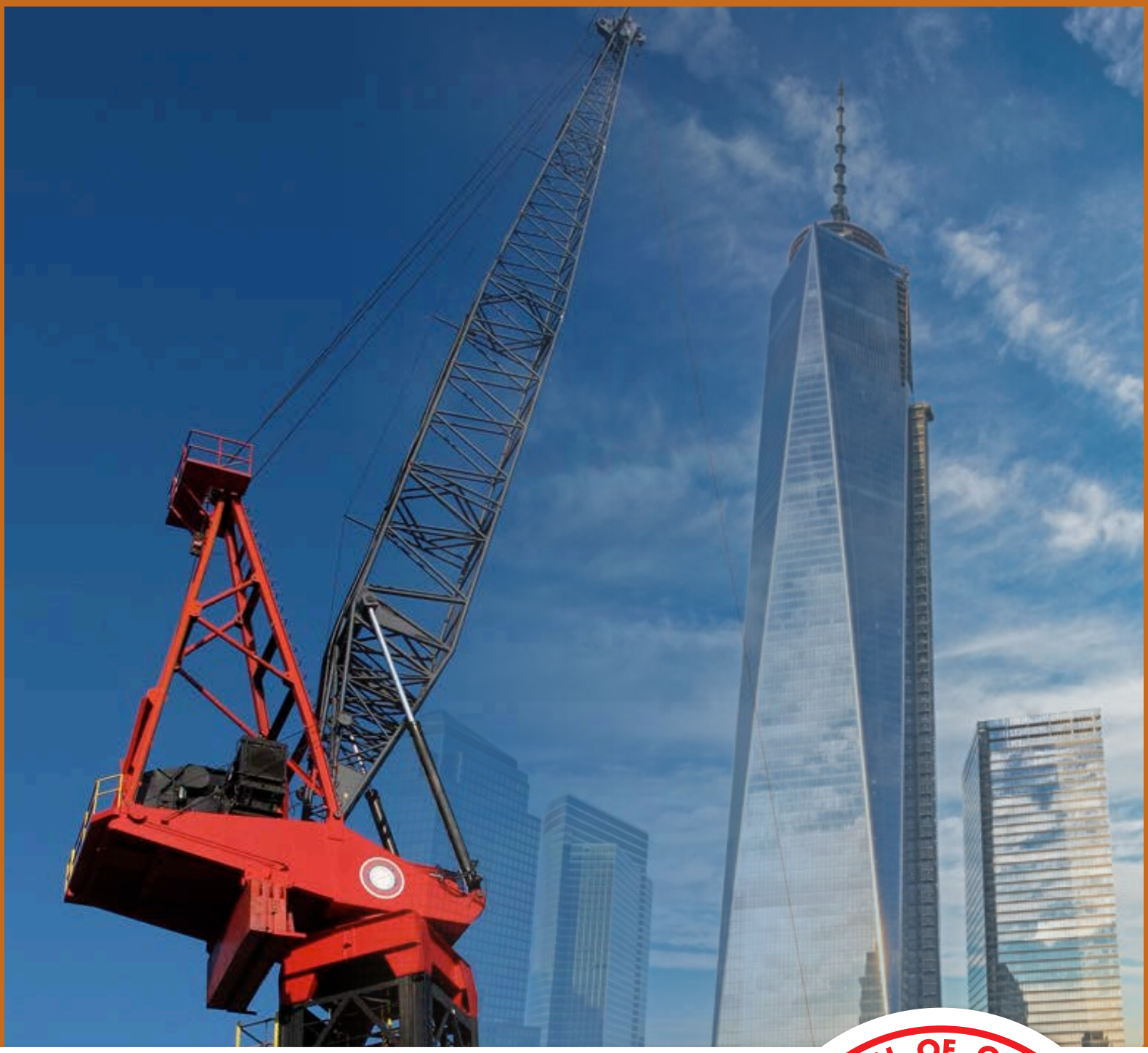

Welfare Fund

Summary Plan Description

Local 14-14B

INTERNATIONAL UNION OF OPERATING ENGINEERS
ORGANIZED DEC. 7, 1896
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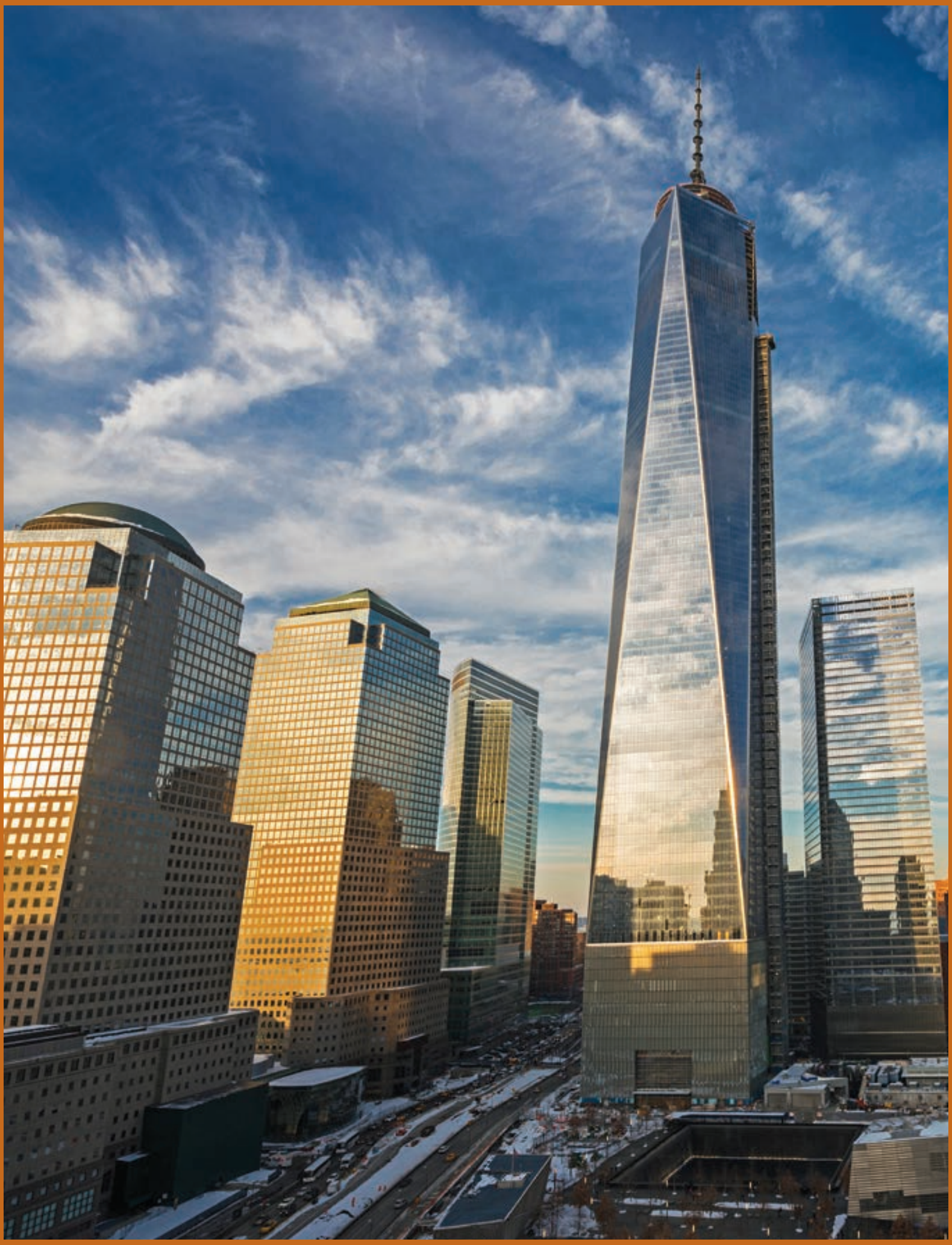

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Introduction

The Board of Trustees is pleased to present you with this new Summary Plan Description (SPD) which highlights the medical, prescription drug, dental, vision, disability, death and accidental death and dismemberment benefits provided through the International Union of Operating Engineers Local 14-14B Welfare Fund (referred to herein as the "Local 14-14B Welfare Fund" or the "Plan").

The Local 14-14B Welfare Fund was established on March 15, 1976 to provide health care benefits to participants and their families who are eligible for comprehensive health care coverage through this Plan. The Plan is financed completely by contributions made by Contributing Employers pursuant to applicable collective bargaining agreements.

This booklet is intended to give you an understanding of the benefits provided by the Local 14-14B Welfare Fund, effective as of January 1, 2018 (except for those provisions that specifically indicate other effective dates), and provides you with information on how the Plan operates. We have tried to organize the information in a way that will be useful to you. If you are not familiar with the terms used in this booklet, please check the Glossary at the back. Generally, terms defined in the Glossary are capitalized throughout this booklet.

This SPD replaces all other SPDs that have previously been provided to you. Please read this booklet carefully and keep it handy for future reference. If you are married, share it with your spouse.

If you have questions, contact the Fund Office by phone at (718) 939-1489, or in writing at 141-57 Northern Boulevard, Flushing, NY 11354.

Sincerely,

BOARD OF TRUSTEES

If you have questions about your Plan benefits, you can call the Fund Office for answers at (718) 939-1489.

This Summary Plan Description (SPD) describes the benefits in effect as of January 1, 2018, for eligible participants of the International Union of Operating Engineers Local 14-14B Welfare Fund. This document replaces and supersedes any previous SPD. Full details are contained in the legal Plan Document. If there is a discrepancy between this booklet and the legal Plan Document, the legal Plan Document will govern. The Trustees reserve the right and have the authority to amend, modify and/or eliminate benefits, or terminate the Plan at any time. In addition, the Trustees, or such other persons as delegated by the Trustees, have the discretion to interpret and construe the rules of the Plan.

Nondiscrimination Notice

Discrimination is Against the Law

The Local 14-14B Welfare Fund or the "Plan" complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The Plan does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

The Plan:

- Provides free assistance and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters; and
  - Written information in other formats (i.e., large print, audio and accessible electronic formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters; and
  - Information written in other languages.

If you need these services, please contact Fund Manager Marlene Monterroso.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of your race, color, national origin, age, disability or sex, you can file a grievance with: Marlene Monterroso, Fund Manager, 141-57 Northern Boulevard, Flushing, NY 11354, Telephone: (718) 939-1489. You can file a grievance in person or by mail, fax or email. If you need assistance to file a grievance, the Fund Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, (800) 368-1019, (800) 537-7697 (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Attention: Free Language Assistance

This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.

Language	Message About Language Assistance
1. Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489
2. Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489.
3. French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489.
4. Italian	ATTENZIONE: Se parla italiano, è disponibile un servizio di assistenza linguistica gratuito. Chiami il numero Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489.
5. German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489.
6. Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489.
7. Arabic	ملحوظة: إذا كنت تتحدث العربية فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489
8. Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489 번으로 전화해 주십시오.
9. Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489.
10. Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489.
11. Urdu	ملاحظہ: اگر آپ اردو بولتے ہیں تو آپ کیلئے زبانی معاونت کی خدمات مفت میں دستیاب ہیں۔ ان نمبرز پر کال کریں Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489.
12. Yiddish	אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489.
13. Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489.
14. French Creole (Haitian)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489
15. Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para Empire (800) 342-9816/CVS/Caremark (888) 766-5519 or (800) 421-2342/Fund Office (718) 939-1489.

Rev. 5/17

Eligibility for Coverage

Once you have met the initial eligibility requirements, your benefits begin on the first day of the first month of the coverage period that follows the day you meet the initial eligibility requirements.

Participant Eligibility

Active Participants. You are eligible to participate in the Plan if you work at least 250 current hours in Covered Employment with a Contributing Employer in a four-month coverage period (also called the "Benefit Fund Stamp Redemption Period").

There are 3 four-month coverage periods: March-June, July-October and November-February. Once you have worked 250 current hours in a four-month coverage period and redeem stamps representing those hours you have worked, you will be eligible for benefits under the Plan. If you lose your stamps, please contact the Fund Office.

The 250 hours must be current; no credit is given for "old" stamps.

Union and Fund Office Staff. Union and Fund Office employees must work 7-1/2 weeks (250 current hours) to become eligible for Local 14-14B Welfare Fund benefits. After meeting initial eligibility, Union and Fund Office staff must be scheduled to work a 35- or 40-hour week each week (depending on job title). Please contact the Fund Office for more details.

Owner/Operators. Local 14-14B Welfare Fund participants who are Owner/Operators are required to contribute 667 hours in Benefit Fund Stamps in any Benefit Fund Stamp Redemption Period in order to be eligible for benefits under the Plan. Failure to do so will result in a loss of eligibility for coverage. For a copy of this coverage policy, contact the Fund Office.

Participants Working out of Town—Reciprocity Agreements. The Local 14-14B Welfare Fund has a reciprocal agreement with the Welfare Funds of the Northeastern District of the IUOE. This agreement was established in order to preserve eligibility and benefits for you as a participant in your home Welfare Fund, regardless of where you may work in the Northeastern District, provided you are working for a Contributing Employer of the out-of-town Welfare Fund. The Northeastern District is covered by the following Welfare Funds:

Local 4 – Boston, MA
Locals 17 & 158 (Districts 106, 545 & 832) – Upstate NY
Local 15 – New York, NY
Local 25 – Manalapan, NJ
Local 57 – Providence, RI
Local 542 – Fort Washington, PA
Local 66 – Pittsburgh, PA
Local 98 – East Longmeadow, MA
Local 137 – Briarcliff Manor, NY
Local 138 – Long Island, NY
Local 478 – Hamden, CT
Local 825 – Springfield, NJ and Orange and Rockland Counties, NY

Transferred Participants. If you transfer from any of the local unions that make up the Northeastern District, you are eligible to receive welfare benefits under this Plan in accordance with the reciprocity agreement with the Northeastern District or any other local union of the IUOE that may enter into a reciprocity agreement with the Welfare Fund at a later date. Under the reciprocity agreement, your original local union's welfare coverage will be primary (pays first) and the Local 14-14B Welfare Fund coverage will be secondary until the primary coverage has been exhausted. Contact your local Fund Administrator for details.

When Your Coverage Begins

There are 3 four-month coverage periods:

1. March 1st through June 30th;

2. July 1st through October 31st; and

3. November 1st through February 28th.

Once you have met the initial eligibility requirements, your benefits begin on the first day of the first month of the coverage period that follows the day you meet the initial eligibility requirements. Your benefits last for the period listed in the following chart, based on the number of hours you work in a coverage period:

Note: You can never be covered for more than 1 year ahead.

Hours worked in a 4-month coverage period:	Coverage will last for:
250 hours	One coverage (stamp redemption) period—4 months in total
500 hours	Next 2 coverage (stamp redemption) periods—8 months in total
750 hours	Next 3 coverage (stamp redemption) periods—12 months in total

Benefit Fund Stamp Redemption Periods. You will receive stamps for the hours you work in Covered Employment with a Contributing Employer and you must redeem stamps with the Fund Office in order to establish your coverage eligibility. Submit stamps to the Fund Office during the designated Benefit Fund Stamp Redemption months of March, July and November.

Example. David first works 300 hours in Covered Employment during the months of November, December, January and February. His coverage becomes effective March 1st and continues through June 30th (4 months total). David also works 600 hours in Covered Employment during the period of March 1st through June 30th. He submits his stamps to establish his eligibility for coverage and his benefits continue through February 28th of the next year (8 months in total).

When You Retire

If you retire at age 62 with active medical benefits, you and your dependents will be eligible for the same medical and prescription drug coverage until you (or your dependents) reach age 65 and/or become eligible for Medicare. Retirees are not eligible for dental, optical or Weekly Loss of Time benefits. These benefits will end for you and your dependents when you retire. However, you will be eligible for a $7,500 Death Benefit.

If you retire at age 65 or become eligible for Medicare, you (and any of your Medicare-eligible dependents) will then be eligible for benefits under the Plan's Medicare Supplemental Benefit. Under this benefit, the Plan **WILL NOT** duplicate the Hospital and medical benefits available under Medicare. It will coordinate with Medicare and only pay the applicable cost sharing under

Medicare Part A (Hospital benefits) and Medicare Part B (physician and medical benefits), up to the amount allowed by Medicare. The Plan **does not** coordinate with Part D (Medicare Prescription Drug coverage). If you enroll in a Medicare Part D Prescription Drug plan, you will not be eligible to receive prescription drug benefits under the Local 14-14B Plan; however, you will not lose your Plan medical coverage.

Retiree Benefits

The Plan will not reimburse Medicare Part B (physician and medical) or Medicare Part D (prescription drug) premium payments.

It is important that you enroll in Medicare Part A and Medicare Part B as soon as you become eligible to do so and that you pay the applicable premium. If you are eligible for Medicare but your spouse is not, regular retiree coverage will continue for your spouse until he/she becomes Medicare eligible. Once your spouse becomes Medicare eligible, he/she will be eligible for benefits under the Fund's Medicare Supplemental Benefit. If your spouse is Medicare eligible but you are not, your spouse will be eligible for benefits under the Fund's Medicare Supplemental Benefit and you will remain covered under the Fund's regular (retiree) coverage until you become Medicare eligible.

Medicare Supplemental Benefits. The Plan will supplement Medicare coverage as follows:

- **Supplemental Medicare Part A (Hospital) Coverage.** The Plan will pay the Deductibles not covered by Medicare. Please refer to the *"Coordination of Benefits—Medicare"* section for more details.
- **Supplemental Medicare Part B (Physician and Medical Benefits) Coverage.** If you ***do not*** enroll in Medicare Part B, you will not receive coverage under the Local 14-14B Welfare Fund. Once you enroll in Medicare Part B, the Plan will pay the Deductible, if not covered by Medicare. The Plan will also pay the Coinsurance charges, generally 20%, that are not covered by Medicare, provided that such charges do not exceed the Plan's scheduled allowance for the particular service(s) rendered. The Plan will only pay up to the amount approved by Medicare. Please refer to the *"Coordination of Benefits—Medicare"* section for more details.
- **Prescription Drug Benefits.** The Plan will pay prescription drug benefits in the same way as it does for actives, whether or not you are Medicare eligible. If you or your spouse enroll in Medicare Part D, your (or your spouse's) prescription drug coverage under the Local 14-14B Plan will end. However, you will continue to be eligible for Medicare Supplemental Benefits.
- **Death Benefit.** You will continue to be covered for a $7,500 Death Benefit provided by the Fund.

When Coverage For Your Dependents Begins

Your dependents are eligible for Plan coverage when you are eligible, provided you enroll them. When you lose eligibility, your dependents also lose their eligibility for coverage.

Your eligible dependents include:

- The **spouse** to whom you are legally married.
- Any of your (as a participant or retiree) children listed below who are under the age of 26, whether married or unmarried, until the end of the month in which they turn age 26:
  - **Natural Children** (copy of certified birth certificate required).

- **Legally Adopted Children and Children Placed With You For Adoption** (copy of certified court order/proof of adoption or placement for adoption and birth certificate required). Place for adoption means the assumption and retention by the participant or eligible retiree of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement for adoption terminates upon the termination of such legal obligation.
- **Stepchildren** (proof of relationship and copy of certified birth certificate required).
- **Children Covered Pursuant to a QMCSO**—You may also cover dependent children for whom Plan coverage has been court-ordered through a Qualified Medical Child Support Order (QMCSO) or through a National Medical Child Support Notice (NMCSN). A copy of this Plan's QMCSO procedures is available free of charge from the Fund Office.

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

- **Handicapped Children**—Extended coverage is available for a child who:
  - Is over age 26, cannot work, and depends on you solely for support because of a mental, developmental or physical disability or illness.
  - Became disabled before reaching age 19.

  You must provide proof to the Fund Office that your child's disability began before he/she reached age 19 and you must do so no later than 31 days after the child's 26th birthday.

  The Fund Office periodically requires substantiation of a child's continued handicap, which may include an examination and proof that the child remains your qualified dependent. Without this proof, coverage may be terminated.
- **Children For Whom You Have Legal Guardianship**—This includes:
  - An individual under age 26 for whom you (as a participant or retiree) have legal guardianship under a court order and who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152 (c) or 152 (d), respectively; OR
  - A child you claim as a dependent on your tax return for each Plan year for which coverage is provided.

  You must provide the Fund Office with proof of guardianship and the child's age.

No individual may be covered under this Plan both as an active participant or retiree and as a dependent, and no individual may be covered under this Plan as both an active participant and a retiree.

A spouse or child of a dependent child is **not** eligible for coverage under the Plan.

Enrolling for Coverage

You must enroll yourself and your dependents in the Plan in order for your coverage to begin.

How to Enroll Yourself and Your Dependents

When you first become eligible for benefits, you must enroll for coverage to begin. In order to enroll yourself and your dependents within 30 days of the date you are first eligible, you must complete and sign an enrollment card, including the beneficiary designation, and return it to the Fund Office.

If you have eligible dependents, you must enroll them when you are first eligible in order for them to be covered and provide the necessary proof of dependent status as listed below. If the Fund Office does not receive a completed enrollment form and the documentation listed below, your dependents will not be eligible for benefits. If you acquire a new dependent after you are initially eligible for benefits, you will also need to complete an enrollment form to add him or her and provide proof of dependent status.

Following is the necessary proof of dependent status:

- **Spouse (Marriage)**—A copy of the certified marriage certificate and Social Security card. If your spouse is employed, you must provide the Fund Office with a letter from your spouse's employer stating that there is no other insurance available. If other coverage is available and your spouse is enrolled, the Fund Office must receive a copy of both sides of the insurance card.
- **Child (Birth)**—A copy of the certified birth certificate and Social Security card.
- **Stepchild**—A copy of the birth certificate listing your spouse as a parent; a copy of the marriage certificate between you and the biological parent; a copy of the stepchild's Social Security card; and a copy of the divorce decree (if applicable) between the biological parents to determine which parent is responsible to provide medical coverage.
- **Adoption or Placement For Adoption**—A certified court order signed by a judge.
- **Disabled Dependent Child**—A current written statement from the child's physician indicating: (1) the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically disabled; (2) an assertion that the child is incapable of self-sustaining employment as a result of that handicap; and (3) an assertion and proof that the child is dependent chiefly on you and/or your spouse for support and maintenance.
- **Child Covered Pursuant to a Qualified Medical Child Support Order (QMCSO)**—Valid certified QMCSO document signed by a judge, or a National Medical Support Notice.
- **Legal Guardianship**—The court-appointed legal guardianship documents and certified birth certificate.

If your spouse is covered under another group health plan, you must report that other coverage to the Fund Office. If your spouse has other coverage and is offered an incentive to opt out of that plan, he/she **may not** waive that coverage and continue to be covered by this Plan. The amount of benefits payable under this Plan will be coordinated with your spouse's other coverage.

Special Enrollment

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll that dependent. You must complete an enrollment card and provide proof of dependent status within 30 days after the marriage, birth, adoption or placement for adoption. You should contact the Fund Office immediately after a child is born, becomes your legal responsibility, or adoption proceedings have begun, to ensure coverage when needed.

If you are declining enrollment for (or do not enroll) a dependent (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your dependent in this Plan if you or your dependent loses eligibility for that other coverage (or if the employer stops contributing towards your or your dependent's other coverage). However, you must request enrollment within 30 days after your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage) and complete an enrollment card to enroll the dependent.

Special enrollment is also allowed under the Plan for you and/or your dependent(s) if:

- You and/or your dependent had coverage under Medicaid or the State Children's Health Insurance Program (SCHIP) and later lost eligibility for the coverage; or
- You and/or your dependent become eligible to participate in a financial assistance program through Medicaid or SCHIP for coverage under the Plan.

You and/or your dependent must request enrollment within 60 days after losing eligibility under SCHIP, or within 60 days of becoming eligible for a financial assistance program through Medicaid or SCHIP.

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

Start of Coverage Following Enrollment

Initial Enrollment—You must enroll for coverage within 30 days of the date you are first eligible.

- If you later add a dependent, your newborn biological child(ren) and adopted newborn(s) will be covered from the date of birth (provided you enroll a baby within 30 days).
- Your adopted dependent child will be covered from the date that child is adopted or "placed for adoption" with you, whichever is earlier. A child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support for the child whom you plan to adopt. A child who is placed for adoption with you within 30 days after the child is born will be covered from birth if you comply with the Plan's requirements for obtaining coverage for a newborn dependent child. However, if a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.
- Coverage for your new spouse begins on the day you marry, provided you properly enroll your spouse within 30 days of your marriage. Refer to page 8 for information on the documentation you will need to provide. Until your spouse is enrolled in the Plan, no claims will be paid for him or her.

Late Enrollment

If you do not enroll your dependents when you or they first become eligible, you may enroll later. However, coverage will not begin until the first day of the month following the month in which the Fund Office receives the completed enrollment form (and the necessary documentation). If you do not properly enroll yourself and/or your dependents, claims for services rendered to you and/or them may be denied until the Fund Office receives the applicable enrollment material.

Qualified Medical Child Support Orders (QMCSO) (Special Rule For Enrollment)

If your spouse and/or dependent child(ren) are covered under another group medical or dental plan, you must report such other coverage to the Fund Office. The amount of benefits payable under this Plan will be coordinated with such other coverage. In addition, if your spouse is eligible for other coverage and does not enroll for that coverage, he/she will not be covered under this Plan.

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

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

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

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

Enrollment Related to a Valid QMCSO: If the Fund Office has determined that an order is a valid QMCSO, it will accept enrollment of the alternate recipient (if not already enrolled in the Plan) as of the earliest possible date following the date the Fund Office determined the order was valid, without regard to typical enrollment restrictions. The QMCSO may require the Plan to provide coverage for the participant's dependent child(ren) for that coverage from a parent who is not a Plan participant. The Fund Office will accept a Special Enrollment of the alternate recipient specified by the QMCSO from either the participant or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified in the QMCSO or if not specified, the first day of the month after the Special Enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, including any requirements for authorization of services, as permitted by applicable law.

Termination of Coverage: Generally, coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other dependent children. When coverage terminates, alternate recipients may be eligible for COBRA continuation coverage. See the COBRA section of this document for details.

If the Fund Administrator determines that a separated or divorced spouse or any state child support or Medicaid agency has obtained a valid QMCSO, you will be required to provide coverage for any child(ren) named in the QMCSO. If you do not enroll the child(ren), the Fund Administrator must enroll the child(ren) upon application from your separated/divorced spouse, the state child support agency, or the Medicaid agency.

You may not drop coverage for the child(ren) unless you submit written evidence that the QMCSO is no longer in effect. The Plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren). ERISA preemption of state laws does not apply to QMCSOs and provisions of state laws requiring medical child support.

The Plan may not deny enrollment of a child under the health coverage of the child's parent on the grounds that the child is born out of wedlock, not claimed as a dependent on the parent's tax return, or is not in residence with the parent or in the applicable service area.

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

Dental and Optical Benefits Opt-Out Provision

You can decline to receive dental and/or optical coverage under the Plan.

There is no option to decline (opt out of) Hospital, medical or prescription drug coverage provided by this Plan. However, in accordance with Health Reform regulations, you do have the option to decline the Plan's Dental and/or Optical benefits. If you wish to decline Dental and/or Optical benefits, contact the Fund Office for the applicable form. You may opt out of Dental/Optical coverage at any time. Changes will be effective the first of the month following the month in which the Fund Office receives your request.

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

Keeping the Fund Office Informed

The best way to ensure fast and accurate claims payment is to make sure the Fund Office has the most up-to-date information for you and your eligible dependents. Please contact the Fund Office whenever you or your spouse have a change in name, address, telephone number, e-mail address, or marital status (marriage, legal separation or divorce), or you need to add an eligible dependent or such a dependent dies.

Keep in mind that if you request PHI by unencrypted e-mail, you should understand that there is some level of risk that the PHI could be read or otherwise accessed by a third party while in transit. If you should request that PHI be sent by unencrypted e-mail, you will receive a brief warning about the risks and will be asked to confirm that you still want to receive your PHI by unencrypted e-mail. If you say yes, the Plan will comply with the request.

When Coverage Ends

When Your Coverage Ends

Benefits terminate on the last day of the last month of the coverage period when you:

- Fail to work at least 250 hours during a coverage period for a Contributing Employer; or
- You enter active military service that lasts more than 31 days (see page 16 for more information on USERRA).

If you do not work the required hours during a coverage/redemption period, your benefits will terminate.

Immediate Cessation of Coverage

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

Under both circumstances, you are required to notify the Fund Office of such event, and you and your eligible dependents may obtain COBRA continuation coverage.

Rescission of Coverage

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

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

Failure to provide complete, updated and accurate information to the Fund Office on a timely basis regarding your marital status, the employment status of a spouse or child, or the existence of other coverage when you enroll a spouse or child, add a spouse or complete the Enrollment Form will constitute an intentional misrepresentation of material fact to the Plan.

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

Reinstating Your Coverage

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

When Coverage For Your Dependents Ends

Coverage ends for your dependents when your coverage ends. In addition:

- Coverage ends for your spouse (and any stepchildren) when you and your spouse are legally divorced and the divorce becomes final. When coverage ends for your spouse (and any stepchildren), your spouse (and any stepchildren) may elect to continue coverage under COBRA for up to 36 months. ***You or your spouse must notify the Fund Office within 60 days of your divorce so that claims are not improperly paid on behalf of your ex-spouse and you may obtain COBRA continuation coverage*** (see page 21). At this time, you may also want to review your beneficiary designation for your death benefit and AD&D benefits, if eligible. In general, once you are divorced, stepchildren from your former marriage are no longer eligible to be covered under the Plan, but may be eligible for COBRA continuation coverage.

  The Fund Office requires you to submit supporting documentation such as a copy of your divorce decree or a copy of any Qualified Medical Child Support Order (QMCSO), if applicable. Contact the Fund Office for a free copy of the Fund's procedures for handling such orders.

- Your child(ren) is no longer eligible for coverage:
  - The end of the month in which he/she turns age 26; or
  - When he/she no longer meets the definition of a dependent.

  Your child may elect to continue coverage by making COBRA self-payments for up to 36 months (see page 22). The Fund Office tracks when a child reaches the limiting age and will notify you when coverage for your child ends. ***However, it is ultimately your responsibility to notify the Fund Office within 60 days of the date the child would otherwise lose coverage in order to protect his or her COBRA rights.***

  Also note that if your child is not capable of self-sustaining employment upon attaining age 26 because he/she is permanently and totally disabled, you may continue coverage for that child for as long as your own coverage continues and the child depends on you for more than one-half of his or her support. To qualify, your child's permanent and total disability must have begun before the child reached age 19. You must submit proof of the disability to the Trustees within 30 days of the date your dependent child's coverage would otherwise end or within 30 days after your dependent child initially becomes eligible for benefits through the Plan.

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

In the Event of Your Death

In the event of your death, your spouse and/or dependent children can continue coverage for 36 months. If you are an active participant and eligible for coverage on the date of your death, your beneficiary will receive a death benefit (and an AD&D insurance benefit, if your death is accidental), subject to the rules for these benefits as explained on pages 70-72 of this SPD.

Your surviving dependents may also be eligible for COBRA continuation coverage following your death and after their additional 36 months of Plan coverage ends (i.e., at the end of the three-year coverage period).

In the event of your death, your spouse or beneficiary should:

- Notify the Fund Office;
- Provide the Fund Office with a copy of your death certificate; and
- Apply for the death benefit (and AD&D insurance, if applicable).

Leave of Absence

The Fund complies with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). This legislation guarantees certain rights to individuals called to active duty in the armed forces of the United States.

Your coverage under this Plan terminates when you enter active duty in the uniformed services. However, you can temporarily continue your coverage through USERRA.

Your coverage under this Plan terminates when you enter active duty in the uniformed services. However, USERRA is a temporary continuation of your coverage when you are called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

- If you elect USERRA temporary continuation coverage, you (and any of your eligible dependents covered under the Plan on the day your leave starts) may continue Plan coverage for up to 24 months measured from the last day of the month in which you stopped working.
- If you go into active military service for up to 31 days, you (and any of your eligible dependents covered under the Plan on the day your leave starts) can continue health care coverage under this Plan during that leave period if you continue to pay the appropriate contributions for that coverage during the period of that leave.

Duty to Notify the Plan. The Plan will offer you USERRA continuation coverage only after you notify the Fund Office, in writing, that you have been called to active duty in the uniformed services and you provide a copy of that order. You must notify the Fund Office as soon as possible but no later than 60 days after the date on which you will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Continuation Coverage. Once the Fund Office receives notice that you have been called to active duty, the Plan will offer you the right to elect USERRA coverage for yourself (and any of your eligible dependents covered under the Plan on the day your leave starts). Unlike COBRA continuation coverage, if you do not elect USERRA for your dependents, those dependents cannot elect USERRA separately. Additionally, you (and any of your eligible dependents covered under the Plan on the day your leave starts) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA continuation coverage and, therefore, either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Fund Office in the same timeframes as is permitted under COBRA continuation coverage.

Paying For USERRA Coverage. If you elect USERRA temporary continuation coverage, you (and any of your eligible dependents covered under the Plan on the day your leave starts) may continue Plan coverage for up to 24 months measured from the last day of the month in which you stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like COBRA coverage. Refer to the section entitled *"Continuation of Coverage (COBRA)"* for more details.

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

After Discharge From the Armed Forces. When you are discharged from military service (not less than honorably), your eligibility will be reinstated on the day you return to work, provided you return to employment within:

- 90 days from the date of discharge from the military if the period of service was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, the time limits are extended up to 2 years.

You must notify the Fund Office in writing within the time periods listed above. Upon reinstatement, your coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to the Fund Office. Questions regarding your entitlement to an approved leave of absence should be referred to your employer.

Coverage Under TRICARE

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

If You Take Family and/or Medical Leave

Under the Family and Medical Leave Act of 1993 (FMLA), as amended, eligibility for benefits must be extended to active participants and their dependents if the active participant is eligible for and has been granted leave by his or her employer pursuant to FMLA, and if the participant's employer makes the required contributions to the Fund.

You are eligible for benefits if your employer grants you a leave of absence under FMLA.

If you are taking FMLA leave that has been approved by your employer, your employer is responsible for making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility.

FMLA Provisions. If you qualify, FMLA allows you to take up to 12 weeks of unpaid leave during any 12-month period for 1 or more of the following reasons:

- The birth, adoption, or placement with you for adoption of a child;
- To care for a seriously ill spouse, parent or child;
- You are unable to work because of a serious illness; or
- You have a qualifying exigency because your spouse, child or parent is on active duty or notified of an impending call to active duty status in support of a contingency military operation as either a member of the reserves component of the Armed Forces of the U.S. or as a retired member of the regular U.S. Armed Forces.

You may be eligible for up to 26 weeks of leave within a single 12-month period to care for a spouse, child, parent or next of kin who is a covered service member suffering from a serious illness or injury sustained in the line of duty, and which renders him or her unfit to perform the duties of his or her office, grade, rank or rating. A "covered service member" is a current member of the U.S. Armed Forces (including the National Guard) who is undergoing medical treatment, recuperation or therapy, and is being treated as an outpatient or is on temporary disability.

Maintenance of Plan Benefits. During your leave, you will continue to receive medical coverage through the Fund if you properly notify your employer of your leave and your employer continues to make contributions to the Fund on your behalf. You are eligible for a leave under FMLA if you:

- Have worked for a covered employer for at least 12 months;
- Have worked at least 1,250 hours during the previous 12 months; and
- You work at a location where at least 50 employees are employed by your employer within a 75-mile radius.

The Fund will maintain your prior eligibility until the end of the leave, provided your employer properly grants the leave under the federal law and makes the required notification and payment to the Fund.

If you and your employer have a dispute over your eligibility and coverage under FMLA, your benefits will be suspended pending resolution of the dispute. The Trustees will have no direct role in resolving such a dispute.

To find out more about FMLA and the terms under which you may be entitled to it, contact your employer.

Paid Family Leave

New York State's Paid Family Leave law provides eligible participants of the Fund who are employed by contributing employers with paid leave to:

1. bond with a newborn, newly adopted or new foster child;

2. take care of a family member with a serious medical condition; or

3. address circumstances arising from a family member's call to active duty with the military.

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

Effective Date	Maximum Leave	Maximum Benefit - Percentage of Employee's Salary
1/1/2018	8 weeks	50% of employee's average weekly wage or 50% of state's average weekly wage, whichever is lower.
1/1/2019	10 weeks	55% of employee's average weekly wage or 55% of state's average weekly wage, whichever is lower.
1/1/2020	10 weeks	60% of employee's average weekly wage or 60% of state's average weekly wage, whichever is lower.
1/1/2021	12 weeks	67% of employee's average weekly wage or 67% of state's average weekly wage, whichever is lower.

Paid Family Leave is provided as a benefit through the Local 14 Welfare Fund in accordance with New York State's Paid Family Leave law as well as the terms and conditions of a policy issued through an insurance carrier. Please contact the Fund Office for more information about how to apply for this benefit.

Continuation of Coverage (COBRA)

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **It explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.**

COBRA continuation coverage allows you to temporarily receive Plan benefits when you experience a qualifying event that would otherwise cause your coverage to end.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event, called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary," including you, your spouse and your dependent children.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you are a participant, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following "qualifying events":

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a participant, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-participant dies;
- The parent-participant's hours of employment are reduced;
- The parent-participant's employment ends for any reason other than his or her gross misconduct;
- The parent-participant becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the participant; and
- The participant becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the participant and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. The written notice should be sent to the Fund Office along with proof of the qualifying event (e.g., a copy of the divorce decree). If the written notice is not received by the Fund Office within 60-days, the qualified beneficiary will NOT be entitled to COBRA.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. The Fund Office will send you information and forms. You need to elect COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Under the law, you and/or your covered dependents have 60 days from the later of the date you receive the notice or lose coverage. If you do not choose COBRA continuation coverage within 60 days, your coverage under the Plan will end. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- **Disability extension of 18-month period of COBRA continuation coverage.** If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in writing in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must notify the Fund Office in writing and provide a copy of the Social Security Disability Award within 60 days after the determination was received by you or your family member.

- **Second qualifying event extension of 18-month period of COBRA continuation coverage.** If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the participant or former participant:
  - Dies;
  - Becomes entitled to Medicare benefits (under Part A, Part B, or both);
  - Gets divorced or legally separated; or
  - If the dependent child stops being eligible under the Plan as a dependent child.

  This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

The COBRA Continuation Coverage That Will Be Provided

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

Paying For COBRA Continuation Coverage (the Cost of COBRA)

Any person who elects COBRA continuation coverage must pay the full cost of the COBRA continuation coverage. The Fund is permitted to charge the full cost of coverage for similarly situated active participants and families, plus an additional 2%. If the 18-month period of COBRA continuation coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

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

NOTE: You will not receive an invoice (bill) for the initial COBRA premium payment or for the monthly COBRA premium payments. You are responsible for making timely payments for COBRA continuation coverage.

Grace Periods

The initial payment for the COBRA continuation coverage is due to the Fund Office no later than 45 days after COBRA continuation coverage is elected. If this payment is not made when due, COBRA continuation coverage will not take effect.

After the initial COBRA payment, subsequent payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made within the 30-day time indicated in this paragraph, COBRA continuation coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Notice of Unavailability of COBRA Continuation Coverage

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

Early Termination of COBRA Continuation Coverage

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

1. The date the premium payment amount due for COBRA continuation coverage is not paid in full and on time;

2. The date the qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) ***after*** electing COBRA;

3. The date, ***after*** the date of the COBRA election, the qualified beneficiary first becomes covered under another group health plan. ***IMPORTANT: The Qualified Beneficiary must notify this Plan by contacting the COBRA Administrator as soon as possible once they become aware that they will become covered under another group health plan.*** COBRA continuation coverage under this Plan ends on the last day of the month in which Qualified Beneficiary becomes covered under the other group health plan;

4. During an extension of the maximum COBRA continuation coverage period to 29 months due to the disability of the qualified beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled; or

5. The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan).

Notice of Early Termination of COBRA Continuation Coverage

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

Once COBRA continuation coverage terminates early, it cannot be reinstated.

Other Coverage Options Besides COBRA Continuation Coverage

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

If You Have Questions

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

Keep the Plan Informed of Address Changes

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

International Union of Operating Engineers
Local 14-14B Welfare Fund
141-57 Northern Boulevard
Flushing, NY 11354
Office Fax: (718) 939-2034
Welfare Fax: (718) 661-3584

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

Medical Benefits

How the Plan's Medical Program Works

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

- "Medically Necessary," but only to the extent that the charges are "Allowed Charges" (as those terms are defined in the *"Glossary,"* beginning on page 112);
- For the diagnosis or treatment of an injury or illness;
- Not services or supplies that are excluded from coverage (which are listed in the *"Medical Benefits Exclusions and Limitations"* section, beginning on page 51); and
- Not services or supplies in excess of a maximum Plan benefit (as shown in the *"Summary of Medical Benefits,"* beginning on page 33).

Generally, the Plan will not reimburse you for any expenses that are not eligible medical expenses. This means you are responsible for paying the full cost of all expenses that are:

- Not determined to be Medically Necessary;
- Determined to be in excess of the Allowed Charge;
- Not covered by the Plan;
- In excess of a maximum Plan benefit; or
- Payable on account of a penalty due to failure to comply with the Plan's Utilization Management requirements, as described later in this document.

Usually, you will have to satisfy a Deductible and/or pay some level of Coinsurance, or pay a Copayment toward the amount of eligible medical expenses you incur. However, once you have reached the Plan's maximum individual out-of-pocket cost in a calendar year, no further Copayments or Coinsurance (for out-of-network benefits) are required from you for the remainder of that calendar year.

Carryover Deductible. Any eligible expenses incurred during the last three months of the previous year that were applied to that year's Deductible (whether or not the full Deductible was satisfied for the previous year) may be carried over and also applied to the Deductible in the new year. As a result, Major Medical benefits will be payable earlier in the new year when the Carryover Deductible provision is applied.

Common Accident Deductible. If any two covered family members are injured in the same accident, all eligible expenses due to the accident will be combined and only one yearly Deductible will be applied to such expenses.

Note that there are different out-of-pocket maximums for in-network and out-of-network benefits, which are described in this section.

Generally, the Plan only covers eligible medical expenses. You are responsible to pay the full cost of expenses that are not Medically Necessary, among others, as described in this section.

Deductible	Copayments	Coinsurance	Annual Out-of-Pocket Maximum
The amount you must pay each calendar year before the Plan pays benefits. The amount applied to the Deductible is the lesser of billed charges or the amount considered to be allowed under this Plan.	A set dollar amount you pay for certain services. After you pay your Copayment, the Plan may pay the rest or most of the rest of the cost of the service.	How you and the Plan will split the cost of certain covered medical expenses, after the Deductible is met.	The maximum amount of Coinsurance that you are responsible for paying each calendar year, in addition to the Deductible, **before** the Plan pays 100% of your covered eligible medical expenses. **Some out-of-pocket expenses (like "balance billing") do not apply to this maximum.**
In-Network: None	**In-Network:** You pay a Copayment for office visits, hospitalization and outpatient Hospital facilities. Generally, the Plan pays the rest of the eligible expenses. See the *"Summary of Medical Benefits"* for Copayment amounts.	**In-Network:** Plan pays 100%. You pay nothing after the applicable Copayment.	**In-Network:** $5,600/person $11,200/family
Out-of-Network: $100/person $200/family	**Out-of-Network:** You pay a Copayment for office visits, hospitalization and outpatient Hospital facilities. Generally, the Plan pays a percentage of the rest of the eligible expenses. See the *"Summary of Medical Benefits"* for Copayment amounts.	**Out-of-Network:** Generally, Plan pays 90%. You pay 10% after the applicable Deductible and/or Copayment.	**Out-of-Network:** $2,000/person Note that expenses used to meet an in-network maximum cannot be applied to meet an out-of-network maximum and vice versa.

Using In-Network Health Care Providers

Empire BlueCross BlueShield is the in-network Hospital and medical services network Provider. You are covered for in-network medical and Hospital benefits under the Empire BlueCross BlueShield EPO network, as outlined in the Certificate of Coverage between Empire BlueCross BlueShield and the Local 14-14B Welfare Fund. Refer to the Certificate of Coverage for detailed information about your In-Network Benefits. If there is a discrepancy between any information in this document about your coverage for in-network medical care and the Certificate, the rules of the Certificate will govern.

In-network health care Providers who are under contract with the Empire BlueCross BlueShield EPO have agreed to accept the discounted amount the Plan pays for Covered Services, plus any additional Copayments you are responsible for paying, as payment in full.

To help you have a clear understanding of how the Plan's benefits work when you receive your care in-network versus out-of-network, the following example illustrates what the out-of-pocket costs might be for a participant who visits a primary health care Provider's office or clinic for treatment of an injury or illness:

Sample Care Costs:	Example of Primary Care Visit	
	In-Network [1]	**Out-of-Network [2]**
Billed charges	$500	$650
Maximum Allowed Amount	$400[1]	$400
Patient's Share of cost that exceeds Maximum Allowed Amount	$0	$250[2]
Patient's Deductible	$0	$100
Patient's Copayment/Coinsurance:	$20 (Copayment only)	$50 (includes $20 Copayment plus 10% Coinsurance after Deductible)
Patient's Total Responsibility:	**$20**	**$400** (includes Deductible, plus $20 Copayment, plus 10% Coinsurance after Deductible, plus balance above Allowed Amount)
Plan Pays:	**$380**	**$250**

[1]*Empire BlueCross BlueShield EPO Network Providers have agreed to accept the Plan's Maximum Allowed Amount as payment and will not balance bill participants.*

[2]*Non-network Providers have not agreed to discount their fees and have the right to bill participants for charges that the Plan does not cover (which is called "balance billing").*

Knowing how to use the EPO to your best advantage will help ensure that you receive high quality health care—with maximum benefits. To get the most from your in-network coverage:

- **Be Sure You Know What's Covered By the Plan.** That way, you and your doctor are better able to make decisions about your health care. Empire will work with you and your doctor so that you can take advantage of your health care options and so you are aware of limits the Plan applies to certain types of care.
- **Always Have Your I.D. Card Handy.** To make an appointment, call your physician's office. Tell them you are an Empire BlueCross BlueShield participant and have your Member ID card handy. They may ask you for your group number, member ID number, or office visit Copayment.
- **Precertify Hospital Admissions and Certain Treatments and Procedures.** Precertification gives you and your doctor an opportunity to learn what the Plan will cover and identify treatment alternatives and the proper setting for care—for instance, a Hospital or your home. Knowing these things in advance can help you save time and money. If you fail to precertify care, if and when required, your benefits may be reduced or denied and you will be responsible for the cost of service.
- **Ask Questions About Your Medical Health Care Options and Coverage.** Call Empire's Member Services department at (800) 342-9816 or (800) 553-9603 (TDD for hearing impaired: (800) 241-6894) when you have questions about your EPO benefits in general or your benefits for a specific medical service or supply; OR call the Fund Office.
- **Visit www.empireblue.com to Locate an EPO Provider Within the Plan's Operating Area.** You can search for Providers by name, address, language spoken, specialty and Hospital affiliation. The search results include a map and directions to the Provider's office. You can also request that a Provider Directory be mailed to you free of charge by calling Member Services at (800) 342-9816.
- **View and Print Up-to-Date Information** about your Plan or request that information be mailed to you by visiting **www.empireblue.com**.

- **Call Empire's 24/7 NurseLine and the AudioHealth Library.** It's available 24 hours a day for you to get recorded general health information, speak to a nurse to discuss health care options, and more.
- **Talk to Your Provider About Your Care.** Ask questions.

Tips for visiting your doctor

- When you make your appointment, confirm that the doctor is an Empire BlueCross BlueShield EPO network Provider and that he/she is accepting new patients.
- Arrange ahead of time to have pertinent medical records and test results sent to the doctor.
- If the doctor sends you to an outside lab or radiologist for tests or x-rays, visit **www.empireblue.com** or call Member Services to confirm that the supplier is in the Empire BlueCross BlueShield EPO network. This will ensure that you receive maximum benefits.
- Ask about a second opinion any time that you are unsure about surgery or a cancer diagnosis.

BlueCard® Worldwide Program

The BlueCard Worldwide program provides Hospital and professional coverage through an international network of health care Providers. With this program, you are assured of receiving care from licensed health care professionals. The program also assures that at least 1 staff member at the Hospital will speak English or the program will provide translation assistance. Here's how to use BlueCard Worldwide:

- Call (804) 673-1177, 24 hours a day, 7 days a week, for the names of participating doctors and Hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct® Access Code.
- Show your ID card at the Hospital. If you are admitted, you will only have to pay for expenses not covered by your contract, such as Copayments, Coinsurance, Deductibles and personal items. Remember to call within 24 hours, or as soon as reasonably possible.
- If you receive outpatient Hospital care or care from a doctor in the BlueCard Worldwide Program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the health care Provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. You will receive reimbursement less any Copayment and amount above the Maximum Allowed Amount.

The SwiftMD Program

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

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

As a SwiftMD member, you can access medical care anytime, anywhere. All of their exclusive U.S.-trained and board-certified emergency and family practice physicians are capable of quickly and accurately diagnosing and treating a host of medical issues by way of a telephone call or video conference.

SwiftMD members avoid drives across town, lengthy waits at the doctor's office, or sitting in an urgent care waiting room. You call the toll free number or login online, answer a few simple health questions, and your case is forwarded to one of their physicians. Within an hour, a SwiftMD doctor will call you for a consultation. You will receive advice, a treatment plan, and a prescription if appropriate. There are no out-of-pocket costs, Copayments or consulting fees for this service.

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

The Medical Management Program

Managing your health includes getting the information you need to make informed decisions, and making sure you get the maximum benefits the Plan will pay. To help you manage your health, the Plan utilizes Empire BlueCross BlueShield's Medical Management Program, a service that precertifies Hospital admissions and certain treatments and procedures to help ensure that you receive the highest quality of care for the right length of time, in the right setting and with the maximum available coverage.

The Medical Management Program works with you and your Provider to help confirm the medical necessity of services and help you make sound health care decisions. To help ensure that you receive the maximum coverage available to you, the Medical Management Program:

- Reviews all planned and emergency Hospital admissions.
- Reviews ongoing hospitalization.
- Performs case management.
- Coordinates discharge planning.
- Coordinates purchase and replacement of durable medical equipment, prosthetics and orthotic requirements.
- Reviews inpatient and Ambulatory Surgery.
- Reviews high-risk maternity admissions.
- Reviews care in a hospice, skilled nursing or other Facility.

All other services are subject to retrospective review by the Medical Management team to determine medical necessity.

It is important for you to remember that the following in-network health care services and supplies must be precertified by the Medical Management Program:

When the following services/supplies are to be received in-network, your doctor must call to precertify.

For All Hospital Admissions

- At least 2 weeks prior to any planned surgery or Hospital admission
- Within 48 hours of an emergency Hospital admission, or as soon as reasonably possible
- Before you are admitted to a rehabilitation Facility or a skilled nursing Facility

Before You Receive/Use

- Inpatient care for surgery or treatment of illness or injury
- Inpatient mental health care, substance abuse care and alcohol detoxification
- Partial Hospital programs, psychological testing, intensive outpatient programs
- Occupational and physical therapy
- Outpatient/ambulatory surgical treatments (certain procedures)
- Diagnostics (certain procedures)
- Outpatient treatments
- Durable medical equipment
- Air ambulance

Precertification Requirement/Penalty. Your doctor should call (800) 982-8089 between the hours of 8:30 a.m. to 5:00 p.m., Monday through Friday for assistance.

While it is your doctor's responsibility to seek precertification, it is recommended that you check with the Hospital, Facility or service Provider to ensure that the care, treatment or supply is precertified before you receive it. **If the call to precertify the services is made as needed, you will receive maximum benefits. Otherwise, your benefits may be reduced by 50%, up to $5,000 for each admission, treatment or procedure.** This benefit reduction also applies to certain Same-Day Surgery and professional services rendered during an inpatient admission. If the admission or procedure is not Medically Necessary, no benefits will be paid.

Services That Do Not Require Precertification. You do not need prior authorization from the Plan or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

In addition, you **do not** need prior authorization from the Plan for out-of-network services. However, keep in mind that these procedures are still subject to retrospective review and medical necessity criteria established by the Fund in conjunction with its medical advisor.

Initial Decisions. Empire will comply with the following timeframes in processing precertification, concurrent and retrospective review of requests for services:

- **Precertification Requests.** Your Provider must contact the Medical Management Program for approval before you receive certain health care services that are subject to precertification. All non-urgent requests for precertification will be reviewed within 3 business days of receipt of all necessary information but not to exceed 15 calendar days from the receipt of the request. If enough information is not provided to make a decision within 15 calendar days, a clinical denial of coverage is rendered. A letter will be sent to you explaining how you can appeal the denial of coverage decision.
- **Concurrent Requests.** Ongoing care is received during your treatment or Hospital stay to be sure you get the right care in the right setting and for the right length of time. When the request to continue care is received at least 24 hours before the last approved day, concurrent reviews of services will be completed within 24 hours of the receipt of the request.

- **Retrospective Requests.** Retrospective review is conducted after you receive medical services. Retrospective reviews of services already provided will be completed within 30 calendar days of receipt of the claim. If enough information is not provided to make a decision within 30 calendar days, a clinical denial of coverage is rendered. A letter will be sent to you explaining how you can appeal the denial of coverage decision. If the Medical Management Program does not meet the above timeframes, the failure should be considered a denial. You or your doctor may immediately appeal.

If the Medical Management Program does not meet the above timeframes, the failure should be considered a denial. You or your doctor may immediately appeal.

If a Request is Denied. All denials of benefits will be rendered by qualified medical personnel. If a request for care or services is denied for lack of medical necessity, or because the service has been determined to be experimental or investigational, the Medical Management Program will send a notice to you and your doctor with the reasons for the denial. You will have the right to appeal. If the Medical Management Program denies benefits for care or services without discussing the decision with your doctor, your doctor is entitled to ask Medical Management to reconsider their decision. A response will be provided by telephone and in writing within 1 business day of making the decision.

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

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

Assistance from Case Management is evaluated and provided on a case-by-case basis. In some situations, the Medical Management Program staff will initiate a review of a patient's health status and the attending doctor's plan of care. They may determine that a level of care is not necessarily desirable, appropriate or cost-effective. If you would like Case Management assistance following an illness or surgery, contact the Medical Management Program at (800) 982-8089.

Summary of Medical Benefits

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

SUMMARY OF MEDICAL BENEFITS		
	In-Network (EPO) You Pay	**Out-of-Network You Pay**
Home, Office/Outpatient Care		
Home/Office Visits	$20 Copayment (non-specialist)	$20 Copayment/visit plus 10% Coinsurance after Deductible, plus balances above Allowed Amount
Specialist Visits	$30 Copayment per visit	$30 Copayment/visit plus 10% Coinsurance after Deductible, plus balances above Allowed Amount
Chiropractic Care (40 visits per calendar year; applicable to participant and participant's spouse ***only***; no dependent child coverage)	$30 Copayment per visit	$30 Copayment/visit plus balances above Allowed Amount
Second or Third Surgical Opinion	$30 Copayment (specialist)	Not covered
Diagnostic Procedures • X-rays, laboratory tests, and other imaging • Radium and Radionuclide therapy • Nuclear cardiology services • MRIs/MRAs, PET/CAT scans	 $0 $50 Copayment per visit $50 Copayment per visit $50 Copayment per test	 Balances above Allowed Amount Balances above Allowed Amount Balances above Allowed Amount $50 Copayment/test plus balances above Allowed Amount
Surgery	$0	Balances above Allowed Amount Assistant surgeon paid at 25% of schedule allowance for out-of-network surgeon
Diabetes Education and Management	$20 Copayment (non-specialist) $30 Copayment (specialist)	Not covered
Pre-Surgical Testing	$0	Balances above Allowed Amount
Anesthesia	$0	Balances above Allowed Amount Claims cannot be processed until surgery claim is received
Chemotherapy, Radiation	$100, one-time initial Copayment	Balances above Allowed Amount
Kidney Dialysis	$100, one-time initial Copayment	Balances above Allowed Amount
Cardiac Rehabilitation (physician services)	$20 Copayment (non-specialist) $30 Copayment (specialist)	Balances above Allowed Amount

SUMMARY OF MEDICAL BENEFITS		
	In-Network (EPO) You Pay	**Out-of-Network You Pay**
Preventive Care		
Annual Physical Exam (1 per calendar year)	$0	10% Coinsurance after Deductible plus balances above Allowed Amount
Diagnostic Screening Tests		
• Cholesterol: 1 every 2 years (except for triglyceride testing)	$0	Balances above Allowed Amount
• Diabetes (if pregnant or considering pregnancy)	$0	Balances above Allowed Amount
• Colorectal cancer ◦ Fecal occult blood test if age 40 or over: 1 per year ◦ Sigmoidoscopy if age 40 or over: 1 every 2 years	$0	Balances above Allowed Amount
• Routine Prostate Specific Antigen (PSA) in asymptomatic males ◦ Over age 50: 1 every year ◦ Between ages 40-49 if risk factors exist: 1 per year ◦ If prior history of prostate cancer, PSA at any age	$0	Balances above Allowed Amount
• Diagnostic PSA: 1 per year	$0	Balances above Allowed Amount
Well-Woman Care		
• Annual Exam	$0	Balances above Allowed Amount
• Office Visit	$0	10% Coinsurance after Deductible plus balances above Allowed Amount
• Bone Density testing and treatment ◦ Ages 52 through 65: 1 baseline ◦ Age 65 and older: 1 every 2 years (if baseline before age 65 does not indicate osteoporosis) ◦ Under Age 65: 1 every 2 years (if baseline before age 65 indicates osteoporosis)	$0	10% Coinsurance after Deductible plus balances above Allowed Amount
• Mammogram (based on age and medical history) ◦ Ages 35 through 39: 1 baseline ◦ Age 40 and older: 1 per year	$0	Balances above Allowed Amount
• Women's sterilization procedures and counseling	$0	Not covered
• Breastfeeding support, supplies and counseling ◦ 1 breast pump per pregnancy	$0	Not covered
• Screenings and/or counseling for: Human Papillomavirus (HPV), sexually transmitted infections (STIs) and Human immune deficiency (HIV).	$0	Not covered

SUMMARY OF MEDICAL BENEFITS		
	In-Network (EPO) You Pay	**Out-of-Network You Pay**
Well-Child Care (Covered Services and the number of visits are based on the prevailing clinical standards of the American Academy of Pediatrics)		

• In-Hospital visits
  ◦ Newborn: 2 in-Hospital exams at birth following vaginal delivery
  ◦ Newborn: 4 in-Hospital exams at birth following C-section delivery
	$0	10% Coinsurance after Deductible plus balances above Allowed Amount

• Office visits
  ◦ From birth up 1st birthday: 7 visits
  ◦ Ages 1 through 4 years: 7 visits
  ◦ Ages 5 through 11 years: 7 visits
  ◦ Ages 12 through 17 years: 6 visits
  ◦ Ages 18 to 21st birthday: 2 visits
	$0	10% Coinsurance after Deductible plus balances above Allowed Amount

• Lab tests ordered at the well-child visits and performed in the office or in the laboratory	$0	10% Coinsurance after Deductible plus balances above Allowed Amount
• Certain immunizations (office visits are not required)	$0	10% Coinsurance after Deductible plus balances above Allowed Amount
Emergency and Urgent Care		
Emergency Room	$200 Copayment per visit (Copayment reduced to $100 if admitted to the same Hospital within 24 hours)	$200 Copayment per visit after Deductible, plus balances above Allowed Amount (Copayment reduced to $100 if admitted to the same Hospital within 24 hours)
Physician's Office	$20 Copayment (non-specialist) $30 Copayment (specialist)	$20 Copayment/visit plus 10% Coinsurance after Deductible, plus balances above Allowed Amount $30 Copayment/visit plus 10% Coinsurance after Deductible, plus balances above Allowed Amount
Urgent Care Services	$20 Copayment per visit	$20 Copayment/visit plus 10% Coinsurance after Deductible, plus balances above Allowed Amount
Emergency Air Ambulance (transportation to nearest acute care Hospital for emergency inpatient admissions)	$0	10% Coinsurance after Deductible plus balances above Allowed Amount
Emergency Land Ambulance (local professional ground ambulance to nearest Hospital)	$0 up to the Maximum Allowed Amount	10% Coinsurance after Deductible plus balances above Allowed Amount

SUMMARY OF MEDICAL BENEFITS		
	In-Network (EPO) You Pay	**Out-of-Network You Pay**
Maternity Care and Infertility Treatment		
Prenatal and Postnatal Care (in doctor's office)	$0	Balances above Allowed Amount
Lab Tests, Sonograms and Other Diagnostic Procedures	$0	Facility: 20% Coinsurance after Deductible plus balances above Allowed Amount Provider: Balances above Allowed Amount
Routine Newborn Nursery Care and Obstetrical Care (in Hospital)	Facility: $100 Copayment per admission Provider: $0	Facility: 20% Coinsurance after Deductible plus balances above negotiated amount Provider: Balances above Allowed Amount
Infertility Treatment (1 cycle per lifetime while covered by the Plan)	$0	Facility: 20% Coinsurance after Deductible plus balances above negotiated amount Provider: Balances above Allowed Amount
Obstetrical Care (in birthing center)	$0	Facility: 20% Coinsurance after Deductible plus balances above negotiated amount Provider: Balances above Allowed Amount
Hospital Services		
Semiprivate Room and Board Includes: • Anesthesia and oxygen • Chemotherapy and radiation therapy • Diagnostic x-rays and lab tests • Drugs and dressing • General special/critical nursing care • Intensive care • Kidney dialysis • Pre-surgical testing	$100 Copayment per admission	$100 Copayment per admission plus 20% Coinsurance after Deductible, plus balances above negotiated amount
Outpatient Facility Includes: • Ambulatory Surgery Facility • Same-day Surgery Facility	$100 Copayment per admission	$100 Copayment per admission plus 20% Coinsurance after Deductible, plus balances above negotiated amount
Cardiac Rehabilitation (inpatient Facility charge)	$100 Copayment per admission	$100 Copayment per admission plus 20% Coinsurance after Deductible, plus balances above negotiated amount
Services of Licensed Physicians and Surgeons	$0	10% Coinsurance after Deductible plus balances above Allowed Amount
Surgery (Inpatient and outpatient)[1]	$0	Balances above Allowed Amount
Anesthesia	$0	Balances above Allowed Amount upon surgical claim review

[1]For a second procedure performed during an authorized surgery through the same incision, The Plan pays for the procedure with the highest Maximum Allowed Amount. For a second procedure done through a separate incision, the Plan will pay the Maximum Allowed Amount for the procedure with the highest allowance and up to 50% of the Maximum Allowed Amount for the other procedure.

SUMMARY OF MEDICAL BENEFITS		
	In-Network (EPO) You Pay	**Out-of-Network You Pay**
Durable Medical Equipment and Supplies		
Durable Medical Equipment (i.e., Hospital-type bed, wheelchair, sleep apnea monitor); covers purchase if cost exceeds rental	$0	Not covered
Skilled Nursing and Hospice Care		
Skilled Nursing Care (inpatient Facility only). Up to 30 days per calendar year	$100 Copayment per admission	Not covered
Hospice (up to 210 days per lifetime)	$0	20% Coinsurance after Deductible plus balances above Allowed Amount
Home Health Care		
Home Health Care (up to 40 visits per calendar year; a visit equals 4 hours of care; includes home infusion therapy)	$0	20% Coinsurance after Deductible plus balances above Allowed Amount
Physical and Occupational Therapy		
Physical Therapy and Rehabilitation Inpatient limited to 30 days per calendar year	$100 Copayment per inpatient admission	$100 Copayment per admission plus 20% Coinsurance after Deductible, plus balances above Allowed Amount.
Outpatient limited to 24 visits per diagnosis	$30 Copayment per outpatient visit	$30 Copayment per outpatient visit plus 10% Coinsurance after Deductible, plus amounts above Allowed Amount
Occupational Therapy Inpatient limited to 30 days per person per calendar year	$100 Copayment per inpatient admission	$100 Copayment per inpatient admission plus 20% Coinsurance after Deductible, plus balances above Allowed Amount.
Outpatient limited to 24 visits per diagnosis Note: Habilitation services are not covered	$30 Copayment per outpatient visit	$30 Copayment per outpatient visit plus 10% Coinsurance after Deductible, plus amounts above Allowed Amount

SUMMARY OF MEDICAL BENEFITS		
	In-Network (EPO) You Pay	**Out-of-Network You Pay**
Mental Health Care		
Mental Health Care Outpatient Services	Office visit: $20 Copayment	Office visit: $20 Copayment per visit plus 10% Coinsurance after Deductible, plus balances above Allowed Amount
	Facility: $100 Copayment per admission	Facility: $100 Copayment per admission plus 20% Coinsurance after Deductible, plus balances above Allowed Amount
Inpatient Services (only semi-private room)	$100 Copayment per admission	$100 Copayment per admission plus 20% Coinsurance after Deductible, plus balances above Allowed Amount
Alcohol or Substance Abuse Treatment		
Alcohol or Substance Abuse Treatment Outpatient Services	Office visit: $20 Copayment	Office visit: $20 Copayment per visit plus 10% Coinsurance after Deductible, plus balances above Allowed Amount
	Facility: $100 Copayment per admission	Facility: $100 Copayment per admission plus 20% Coinsurance after Deductible, plus balances above Allowed Amount
Inpatient Services (only semi-private room)	$100 Copayment per admission	$100 Copayment per admission plus 20% Coinsurance after Deductible, plus balances above Allowed Amount

Eligible Covered Medical Expenses

The following provides detailed information about the Plan's covered medical services:

Along with the Summary of Medical Benefits, this list provides detailed information about medical services covered by the Plan.

- **Consultation** requested by the attending physician for advice on an illness or injury is covered.
- **Preventive Care (in-network only).** Preventive care services, which include outpatient services and office services, are covered in full by this Plan in-network only. This means that you do not have to pay a Deductible, Copayment or Coinsurance when you receive the following preventive care services from an In-Network Provider. Preventive care services in this section meet requirements as determined by Federal law. These services fall under 4 broad categories as shown below:
  - Items or services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;
    - Type 2 diabetes mellitus;
    - Cholesterol; and
    - Child and adult obesity.
  - Immunizations pursuant to the Advisory Committee on Immunization Practices (ACIP) recommendations, including the well-child care immunizations as listed below:
    - DPT (diphtheria, pertussis and tetanus);
    - Polio;
    - MMR (measles, mumps and rubella);
    - Varicella (chicken pox);
    - Hepatitis B Hemophilus;
    - Tetanus-diphtheria;
    - Pneumococcal;
    - Meningococcal Tetramune; and
    - Other immunizations as determined by the Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives.
  - Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), including:
    - Well-child care visits to a pediatrician, nurse or licensed nurse practitioner, including a physical examination, medical history, developmental assessment and guidance on normal childhood development and laboratory tests. The tests may be performed in the office or

a laboratory. Covered Services and the number of visits covered per year are based on the prevailing clinical standards of the American Academy of Pediatrics (AAP) and will be determined by your child's age.

- Bone density testing and treatment. Standards for determining appropriate coverage include the criteria of the Federal Medicare program and the criteria of the National Institutes of Health for the Detection of Osteoporosis. Bone mineral density measurements or tests, drugs and devices include those covered under Medicare and in accordance with the criteria of the National Institutes of Health, including, as consistent with such criteria, dual energy x-ray absorptiometry. Coverage will be available as follows:

  For individuals who are:

  - Ages 52 through 65 - 1 baseline;
  - Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis); and
  - Under Age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis).
  - For individuals who meet the criteria of the above programs, including 1 or more of the following:
  - Have been previously diagnosed with or have a family history of osteoporosis;
  - Have symptoms or conditions indicative of the presence or significant risk of osteoporosis;
  - Have a prescribed drug regimen that poses a significant risk of osteoporosis;
  - Have lifestyle factors to such a degree they pose a significant risk of osteoporosis; and/or
  - Have age, gender and/or other physiological characteristics that pose a significant risk of osteoporosis.

- Women's Preventive Care: Additional preventive care and screenings for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  - Well-woman care visits to a gynecologist/obstetrician;
  - Women with no prior or family history of breast cancer, get a baseline mammogram between ages 35-39, and for ages 40 and over an annual mammogram. Women who have a family history of breast cancer will be covered for a routine mammogram at any age and as often as their physician recommends one;
  - Women's contraceptives, sterilization procedures and counseling: This includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants, as well as injectable contraceptives;
  - Breastfeeding support, supplies and counseling. Benefits for breast pumps are limited to 1 pump per pregnancy;

- Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30-pack per year smoking history and currently smoke or have quit within the past 15 years; and
- Screenings and/or counseling, where applicable, for: Hepatitis C, Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV) and interpersonal and domestic violence.

The preventive services referenced above will be covered in full when received from In-Network Providers. Cost sharing (e.g., Copayments, Deductibles, and Coinsurance) may apply to services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit and that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

A list of the preventive services covered by the Plan is available on the EPO Provider's website at **www.empireblue.com** or will be mailed to you upon request. You may request the list by calling the Customer Service number on your identification card.

- **Diabetic Supplies** prescribed by an authorized Provider that are covered include:
  - Blood glucose monitors, including monitors for the legally blind;
  - Testing strips;
  - Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices;
  - Oral agents for controlling blood sugar;
  - Other equipment and supplies required by the New York State Health Department; and
  - Data management systems.
- **Diabetes Self-Management** education and diet information is covered, including:
  - Education by a physician, certified nurse practitioner or member of their staff:
    - At the time of diagnosis;
    - When the patient's condition changes significantly; and
    - When Medically Necessary;
  - Education by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian when referred by a physician or certified nurse practitioner. This benefit may be limited to a group setting when appropriate. Includes 1 visit to nutritionist for non-obese individuals; and
  - Home visits for education when Medically Necessary.
- **Diagnosis and Treatment of Degenerative Joint Disease** related to temporomandibular joint (TMJ) syndrome is not covered.

- **Hearing Examinations** are covered when they are Medically Necessary.
- **Foot Care** associated with disease affecting the lower limbs such as severe diabetes, which requires care from a podiatrist or physician, is covered.
- **Chiropractic Care** is covered.
- **Treatment Related to Mastectomy.** Federal law imposes certain requirements on employee benefit plans and health insurers that provide medical and surgical benefits with respect to a mastectomy. Specifically, in the case of a participant or beneficiary who receives benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the law requires coverage for:
  - Reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

  Coverage will be provided in a manner determined in consultation with the attending physician and the patient. This coverage is subject to all coverage terms and limitations (for example, Deductibles and Coinsurance) consistent with those established for other benefits under the plan.
- **Emergency Care.** Emergency care is covered in the Hospital emergency room. To be covered as emergency care, the condition must be a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
  - Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
  - Serious impairment to such person's bodily functions;
  - Serious dysfunction of any bodily organ or part of such person; or
  - Serious disfigurement of such person.

  Emergency services are not subject to prior authorization requirements.

  You pay only a Copayment for a visit to an emergency room. This Copayment is reduced from $200 to $100 if you are admitted into the Hospital within 24 hours. If you make an emergency visit to your doctor's office, you pay the same Copayment as for an office visit. Benefits for treatment in a Hospital emergency room are limited to the initial visit for an emergency condition. A participating Provider must provide all follow-up care in order to receive maximum benefits.

  Refer to page 31 for details regarding precertification requirements.

- **Urgent Care Services.** An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an emergency room. Urgent health problems include earache, sore throat and fever (not above 104 degrees). Benefits for urgent care include:
  - X-ray services;
  - Care for broken bones;
  - Tests such as flu, urinalysis, pregnancy test, and rapid strep;
  - Laboratory services, stitches for simple cuts; and
  - Draining an abscess.

  Covered urgent care services can be received in a doctor's office, an urgent care Facility or an outpatient Facility. An urgent care Facility is a licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care services.

  Benefits may vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Refer to the *"Summary of Medical Benefits,"* beginning on page 33, for more details on how benefits vary in each setting.

If you need urgent care, call your physician or your physician's backup. You can also call the EPO's 24/7 NurseLine at (877) TALK2RN (825-5276) for advice, 24 hours a day, 7 days a week.

- **Emergency Air Ambulance.** Air ambulance is provided to transport you to the nearest acute care Hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care when the following conditions are met:
  - Your medical condition requires immediate and rapid ambulance transportation and services cannot be provided by land ambulance due to great distances, and the use of land transportation would pose an immediate threat to your health; and
  - Services are covered to transport you from 1 acute care Hospital to another, only if the transferring Hospital does not have adequate facilities to provide the Medically Necessary services needed for your treatment as determined by Empire, and use of land ambulance would pose an immediate threat to your health.

  If the Plan determines that the condition for coverage for air ambulance services have not been met but your condition did require transportation by land ambulance to the nearest acute care Hospital, the Plan will only pay up to the Maximum Allowed Amount that would be paid for land ambulance to that Hospital.

  Please refer to page 31 for details regarding precertification requirements.

- **Emergency Land Ambulance.** You are covered for land ambulance transportation to the nearest acute care Hospital, in connection with emergency room care or emergency inpatient admission, when provided by an ambulance service. Coverage applies when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:
  - Placing the participant's health afflicted with a condition in serious jeopardy, or for behavioral condition, place the health of a participant or others in serious jeopardy;
  - Serious impairment to a person's bodily functions;

- Serious dysfunction of any bodily organ or part of a person; or
- Serious disfigurement to the participant.

Benefits are not available for transfers of covered participants between health care facilities.

- **Maternity Care.** There are no out-of-pocket expenses for maternity and newborn care when you use In-Network Providers. That means you do not need to pay a Copayment when you visit the obstetrician. Furthermore, routine tests related to pregnancy, obstetrical care in the Hospital or birthing center, as well as routine newborn nursery care are all covered 100% in-network.

  Covered Services include but are not limited to:

  - One home care visit, which is fully covered if the mother leaves earlier than the 48-hour (or 96-hour) limit. The mother must request the visit from the Hospital or a home health care agency within this timeframe. The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later;
  - Services of a certified nurse-midwife affiliated with a licensed Facility. The nurse-midwife's services must be provided under the direction of a physician;
  - Parent education, and assistance and training in breast or bottle feeding, if available;
  - Circumcision of newborn males;
  - Special care for the baby if the baby stays in the Hospital longer than the mother; and
  - Semi-private room.

Contact the Future Moms Program for help during pregnancy. A complimentary book on prenatal care is waiting for you when you enroll. Call (800) 845-4742 and listen for the prompt that says "precertify." You will be transferred to the Future Moms Program.

Future Moms Program

The Plan offers the "Future Moms Program," wherein specially trained obstetrical nurses working with you and your doctor help you and your baby obtain appropriate medical care throughout your pregnancy, delivery and after your baby's birth. The program also helps identify high-risk pregnancies. If necessary, the EPO will suggest a network specialist to you who is trained to deal with complicated pregnancies. The Plan can also provide home health care referrals and health education counseling.

Obstetrical care in the Hospital or an in-network birthing center is covered up to 48 hours after a normal vaginal birth and 96 hours after a cesarean section.

Use a network obstetrician/gynecologist to receive the lowest cost maternity care.

Newborns' and Mothers' Health Protection Act of 1996

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 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 program or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

- **Infertility Treatment.** Infertility as defined in regulations of the New York State Insurance Department means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse, as further defined in the regulations. The Plan covers the following medical and surgical procedures once per lifetime:
  - Artificial insemination;
  - Intrauterine insemination;
  - Dilation and curettage (D&C), including any required inpatient or outpatient Hospital care that would correct malformation, disease or dysfunction resulting in infertility; and
  - Services in relation to diagnostic tests and procedures necessary to determine infertility; or
  - In connection with any surgical or medical procedures to diagnose or treat infertility, the following diagnostic tests and procedures:
    - hysterosalpingogram
    - hysteroscopy
    - endometrial biopsy
    - laparoscopy
    - sono-hysterorgram
    - post-coital tests
    - testis biopsy
    - semen analysis
    - blood tests
    - ultrasound
    - other Medically Necessary diagnostic tests and procedures, unless excluded by law.

    Services must be Medically Necessary and must be received from eligible Providers as determined by the Plan in accordance with applicable regulations of the New York State Insurance Department. In general, an eligible Provider is defined as a health care Provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine for the performance of procedures and treatments for the diagnosis and treatment of infertility.

    Prescription drugs approved by the FDA specifically for the diagnosis and treatment of infertility that are not related to any excluded services are covered, subject to all the conditions, exclusions, limitations and requirements that apply to all other prescription drugs under this Plan. Refer to page 55 for information regarding your prescription drug coverage.

- **Services For Advanced Reproductive Technologies.** The following services are covered for participants who are infertile and who have failed to achieve a pregnancy through the use of other generally acceptable methodologies of treating infertility. These services are available on an in-network basis, 1 cycle per lifetime:
  - The following advanced reproductive technology procedures:
    i. In-vitro Fertilization (IVF)
    ii. Zygote Intrafallopian Transfer (ZIFT)
    iii. Gamete Intrafallopian Transfer (GIFT)
    iv. Intracytoplasmic Sperm Injection (ICSI)

- Medically Necessary and appropriate diagnostic workup and radiology services.
- Pathology and laboratory services, including:
  i. Hormonal assays;
  ii. Swim up semen analysis, as appropriate;
  iii. Ultrasound exams;
  iv. Fertilization and embryo culture;
  v. Ova retrieval; and
  vi. Embryo, gamete-zygote transfer.

- **Clinical Trials.** Routine patient costs for items and services furnished in connection with participation in an approved clinical trial for cancer and other life-threatening conditions are covered, if the Plan would provide those items and services to patients not participating in a trial.

- **Hospital Services.** You are covered for Medically Necessary care when you stay at a Hospital for surgery or treatment of an illness or injury. You are also covered for same-day (outpatient or ambulatory) Hospital services, such as chemotherapy, radiation therapy, cardiac rehabilitation and kidney dialysis. Same-day surgical services or invasive diagnostic procedures are covered when they:
  - Are performed in a same-day or Hospital outpatient surgical Facility;
  - Require the use of both surgical operating and postoperative recovery rooms;
  - May require either local or general anesthesia;
  - Do not require inpatient Hospital admission because it is not appropriate or Medically Necessary; and
  - Would justify an inpatient Hospital admission in the absence of a Same-Day Surgery program.

  Refer to page 31 for details regarding precertification requirements for Hospital care.

  When you use a network Hospital, you will not need to file a claim in most cases.

Pre-Surgical Testing

Benefits are available for pre-surgical testing on an outpatient basis, when performed at the Hospital where the surgery is scheduled to take place, if:

- Reservations for a Hospital bed and for an operating room at that Hospital have been made prior to performance of the tests;
- The participant's doctor has ordered the tests; and
- Proper diagnosis and treatment require the tests.

The surgery must take place within 7 days after these tests. If surgery is canceled because of these pre-surgical test findings or as a result of a voluntary second opinion on surgery, the Plan will still cover the cost of these tests, but they will not be covered when the surgery is canceled for any other reason.

Tip for getting Hospital care

If you are having Same-Day Surgery, often the Hospital or outpatient Facility requires that someone meet you after the surgery to take you home. Ask about their policy and make arrangements for transportation before you go in for surgery.

Inpatient and Outpatient Hospital Care

Following are additional Covered Services and limitations for both inpatient and outpatient (same-day) care:

- Diagnostic x-rays and lab tests, and other diagnostic tests such as EKG's, EEG's or endoscopies;
- Oxygen and other inhalation therapeutic services and supplies and anesthesia (including equipment for administration). If you or your covered dependent receive surgical benefits and anesthesia is administered by a doctor (other than the operating surgeon, his assistant, an employee of a Hospital or similar institution, or a Certified Registered Nurse Anesthesiologist (CRNA)), the anesthesiologist's fee will be reimbursed up to 50% of the allowable surgical benefit upon review of the surgery claim;
- Anesthesiologist, including 1 consultation before surgery and services during and after surgery;
- Blood and blood derivatives for emergency care, Same-Day Surgery or Medically Necessary conditions, such as treatment for hemophilia;
- MRIs/MRAs, PET/CAT scans and nuclear cardiology services; and
- Semi-private room and board when the patient is under the care of a physician, and a Hospital stay is Medically Necessary.

Coverage is for unlimited days unless otherwise specified:

- Operating and recovery rooms;
- Special diet and nutritional services while in the Hospital;
- Cardiac care unit;
- Services of a licensed physician or surgeon employed by the Hospital;
- Care related to surgery; and
- Breast cancer surgery (lumpectomy, mastectomy). Refer to page 42 for information regarding coverage for reconstruction following surgery.

Also covered are:

- Use of cardiographic equipment;
- Drugs, dressings and other Medically Necessary supplies;
- Social and psychological services;
- Reconstructive surgery associated with injuries unrelated to cosmetic surgery;
- Reconstructive surgery for a functional defect which is present from birth;
- Physical and occupational therapy including facilities, services, supplies and equipment; and
- Facilities, services, supplies and equipment related to Medically Necessary medical care.

Following are additional Covered Services for same-day care:

- Same-day and Hospital outpatient surgical facilities;
- Surgeons;

- Surgical assistant if none is available in the Hospital or Facility where the surgery is performed, and the surgical assistant is not a Hospital employee;
- Chemotherapy and radiation therapy, including medications, in a Hospital outpatient department, doctor's office or Facility. Medications that are part of outpatient Hospital treatment are covered if they are prescribed by the Hospital and filled by the Hospital pharmacy; and
- Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) in the following settings until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare:
  - At home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered); and
  - In a Hospital-based or freestanding Facility. Refer to "Hospital/Facility" in the *"Glossary."*

- **Durable Medical Equipment and Supplies.** You are covered for the following Medically Necessary prosthetics and durable medical equipment and medical supplies from network suppliers only:
  - Durable medical equipment from network suppliers, including:
    - Artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses;
    - Supportive devices essential to the use of an artificial limb;
    - Corrective braces; and
    - Wheelchairs, Hospital-type beds, oxygen equipment and sleep apnea monitors.
  - Rental (or purchase when more economical) of Medically Necessary durable medical equipment;
  - Replacement of covered medical equipment because of wear, damage or change in patient's need, when ordered by a physician;
  - Reasonable cost of repairs and maintenance for covered medical equipment; and
  - Disposable medical supplies such as syringes.

  Refer to page 31 for details regarding precertification requirements.

- **Skilled Nursing Care.** You receive coverage for inpatient care in a skilled nursing Facility. ***Benefits are available for in-network facilities only.*** You are covered for inpatient care for a set number of days per calendar year in an in-network skilled nursing Facility, if you need medical care, nursing care or rehabilitation services. Prior hospitalization is required in order to be eligible for this benefit. Refer to page 31 for details regarding precertification requirements.

- **Hospice Care.** You receive coverage for up to 210 days of hospice care during your (a covered person's) lifetime. Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of 6 months or less. Hospice care can be provided in a hospice, in the hospice area of a network Hospital, or at home. Covered Services include:
  - Up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN);
  - Medical care given by the hospice doctor;
  - Drugs and medications prescribed by the patient's doctor that are not experimental and are approved for use by the most recent Physicians' Desk Reference;
  - Physical, occupational and respiratory therapy when required for control of symptoms;
  - Laboratory tests, x-rays, chemotherapy and radiation therapy;
  - Social and counseling services for the patient's family, including bereavement counseling visits until 1 year after death;
  - Transportation between home and Hospital or hospice when Medically Necessary;
  - Medical supplies and rental of durable medical equipment; and
  - Up to 14 hours of respite care in any week.
- **Home Health Care and Home Infusion Therapy.** If you receive care from an in-network home health care agency or home infusion supplier, the EPO cannot bill you for Covered Services. If you receive a bill from an In-Network Provider, contact the EPO Member Services line, (800) 342-9816.

  The Plan covers:
  - Up to 40 home health care visits per calendar year. A visit is defined as up to 4 hours of care. Care can be given for up to 12 hours a day (3 visits). Your physician must certify home health care as Medically Necessary and approve a written treatment plan;
  - Part-time services by a registered nurse (RN) or licensed practical nurse (LPN);
  - Part-time home health aide services (skilled nursing care);
  - Physical or occupational therapy, if restorative;
  - Medications, medical equipment and supplies prescribed by a doctor; and
  - Laboratory tests.
- **Physical and Occupational Therapy.** You receive coverage for outpatient physical and occupational therapy provided by an In-Network Provider. Refer to page 31 for details regarding precertification requirements. The Plan also covers the following:
  - Physical therapy, physical medicine or rehabilitation services, or any combination of these, on an inpatient or outpatient basis, up to the Plan maximums if:
    - Prescribed by a physician; and
    - Designed to improve or restore physical functioning within a reasonable period of time.

- Outpatient care must be given at home, in a therapist's office or in an outpatient Facility by an In-Network Provider. Inpatient therapy must be short-term. The Plan covers occupational, or any combination of therapies on an outpatient basis up to the Plan maximums if:
  - Prescribed by a physician or in conjunction with a physician's services; and
  - Given by skilled medical personnel at home, in a therapist's office or in an outpatient Facility.

- **Behavioral Health Care.** Your behavioral health care benefits cover outpatient treatment for alcohol or substance abuse, inpatient detoxification, inpatient alcohol and substance abuse rehabilitation and inpatient and outpatient mental health care. Refer to page 31 for details regarding precertification requirements. Covered Services also include the following:
  - Electroconvulsive therapy for treatment of mental or behavioral disorders, if precertified by Behavioral Healthcare Management;
  - Care from psychiatrists, psychologists or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have 3 years of post-degree supervised experience in psychotherapy and an additional 3 years of post-licensure supervised experience in psychotherapy;
  - Treatment in a New York State Health Department-designated Comprehensive Care Center for Eating Disorders pursuant to Article 27-J of the New York State Public Health Law; and
  - Family counseling services for alcohol or substance abuse at an outpatient treatment Facility. These can take place before the patient's treatment begins. Any family member covered by the Plan may receive Medically Necessary counseling visits.
- **Smoking Intervention.** The Plan provides coverage for interventions, including education or counseling, to prevent the initiation of tobacco use in school-aged children and adolescents.

Medical Benefits Exclusions and Limitations

The following services and/or supplies are not covered under the Plan's medical program:

- Dental services, including but not limited to:
  - Treatment for cavities;
  - Extractions;
  - Care of gums;
  - Treatment of bones supporting the teeth or periodontal abscess;
  - Orthodontia;
  - False teeth;
  - Mouth guard; and
  - Treatment of temporomandibular joint dysfunction (TMJ).

Dental benefits are provided as a stand-alone (or excepted) benefit. Refer to the *"Dental Benefits"* section for information regarding dental coverage.

- Experimental, investigational or obsolete treatments and procedures.
- Government services covered under government programs, except Medicaid or where otherwise noted. Also, government Hospital services, except:
  - Specific services covered in a special agreement between the EPO Provider and a government Hospital; and
  - United States Veterans' Administration or Department of Defense Hospitals, except services in connection with a service-related disability. In an emergency, the Plan will provide benefits until the government Hospital can safely transfer the patient to a participating Hospital.
- Home care (services performed at home), except for those services specifically noted elsewhere in this SPD as available either at home or as an emergency.
- Inappropriate billing, such as:
  - Services usually given without charge, even if charges are billed; and/or
  - Services performed by Hospital or institutional staff, which are billed separately from other Hospital or institutional services, except as specified.
- Medically unnecessary services, such as services, treatment or supplies not Medically Necessary in the Plan's judgment.
- All prescription drugs and over the counter drugs, self-administered injectables, vitamins, appetite suppressants, oral contraceptives, injectable contraceptives, contraceptive patches and diaphragms or any other type of medication, unless specifically indicated or required under the Affordable Care Act. Generally, such medications and supplies are covered by the Plan under the prescription drug provisions. Refer to the *"Prescription Drug Benefits"* section for information regarding prescription drug coverage.
- Travel, even if associated with treatment and recommended by a doctor.
- Services for illness or injury received as a result of war.

You are covered for expenses you incur for most, but not all, medical services and supplies. This section identifies the services and supplies that are not covered under the Plan's medical program.

- Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.
- Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party. For example, in instances when an insurance company must pay the claims that result from the acts of another person, such as for any accident coverage, "no fault" coverage, uninsured or underinsured motorist coverage, personal injury protection, and homeowners insurance.
- Routine foot care, including care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain.
- Symptomatic complaints of the feet except capsular or bone surgery related to bunions and hammertoes.
- Orthotics for treatment of routine foot care.
- Routine vision care. Eyeglasses, contact lenses and the examination for their fitting, except following cataract surgery, unless specifically indicated. Corrective lenses not covered after cataract surgery. Refer to page 64 for information on the Plan's vision program.
- Routine hearing exams, unless specifically indicated and Medically Necessary.
- Hearing aids and the examination for their fitting.
- Services such as laboratory, x-ray and imaging, and pharmacy services as required by law from a Facility in which the referring physician or his/her immediate family member has a financial interest or relationship.
- Services given by an unlicensed Provider or performed outside the scope of the Provider's license.
- Use of the emergency room:
  - To treat routine ailments;
  - Because you have no regular physician; or
  - Because it is late at night (and the need for treatment is not sudden and serious).
- Emergency services for ambulette.
- The following maternity care services:
  - Days in Hospital that are not Medically Necessary (beyond the 48-hour/96-hour limits);
  - Services that are not Medically Necessary;
  - Private room;
  - Out-of-network birthing center facilities; and
  - Private duty nursing.
- Reversal of elective sterilizations, including vasectomies and tubal ligations.
- Cloning.
- Medical or surgical services or procedures that are experimental.

- Any procedure for which donated ova or donated sperm are used.
- Embryo cryo preservation of fees associated with it.
- Fallopian tube ligations and vasectomy reversals.
- Surrogacy and any fees associated with it.
- Services requested that are not medically appropriate, including but not limited to ovarian failure or obesity where the chances of successful pregnancy are substantially diminished.
- Services not specifically listed as covered in the *"Summary of Medical Benefits."*
- The following inpatient services:
  - Private duty nursing;
  - Private room. If you use a private room, you need to pay the difference between the cost for the private room and the Hospital's average charge for a semi-private room;
  - Diagnostic inpatient stays, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life; and
  - Services performed in the following:
    - Nursing or convalescent homes;
    - Institutions primarily for rest or for the aged;
    - Rehabilitation facilities (except for physical therapy and mental health/substance abuse);
    - Spas;
    - Sanitariums; and
    - Infirmaries at schools, colleges or camps.
  - Any part of a Hospital stay that is primarily custodial;
  - Elective cosmetic surgery or any related complications;
  - Hospital services received in clinic settings that do not meet the Plan's definition of a Hospital or other covered Facility in the *"Glossary;"* and
  - Residential treatment services.
- The following outpatient services:
  - Same-Day Surgery not precertified as Medically Necessary by the Plan's Medical Management Program;
  - Routine medical care including but not limited to:
    - Inoculation or vaccination;
    - Drug screening; and
    - Drug administration or injection, excluding chemotherapy; and
  - Collection or storage of your own blood, blood products, semen or bone marrow.
- The following durable medical equipment:
  - Air conditioners or purifiers;

- Humidifiers or dehumidifiers;
- Exercise equipment;
- Orthotics;
- Swimming pools;
- False teeth;
- Hearing aids; and
- Prosthetics.

- The following skilled nursing care services:
  - Skilled nursing Facility care that primarily:
    - Gives assistance with daily living activities;
    - Is for rest or for the aged;
    - Treats drug addiction or alcoholism;
    - Convalescent care;
    - Sanitarium-type care; and
    - Rest cures.
- The following home health care services:
  - Custodial services, including bathing, feeding, changing or other services that do not require skilled care; and
  - Out-of-network home infusion therapy.
- The following therapy services:
  - Therapy to maintain or prevent deterioration of the patient's current physical abilities; and
  - Tests, evaluations or diagnoses received within the 12 months prior to the doctor's referral or order for occupational therapy.
- No coverage is provided under this Plan for services or supplies related to the screening, diagnosis, and/or treatment of ADHD, ADD and autism spectrum disorder including but not limited to: screening and diagnostic services, assistive communication devices, behavioral health treatment including applied behavioral analysis (ABA), all therapy including physical, occupational, and speech therapy, prescription drugs, or any services or treatment that are provided pursuant to an individualized (or family) education plan under the New York Education Law or other similar state law. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.
- No coverage is provided for any services or treatment that are provided pursuant to an individualized, family education plan or other similar such plan under the New York Education Law or other similar state law. However, the Plan will provide supplemental coverage for any expenses that would otherwise be covered under the Plan after payment is made pursuant to such a plan.

Prescription Drug Benefits

Prescription drug coverage is one of the most important and utilized benefits that a plan offers. Recognizing the importance of this coverage, the Plan has contracted with CVS/Caremark to ensure you receive comprehensive prescription drug benefits.

At the Pharmacy

Your prescription ID card is the same as your medical ID card and identifies you and your eligible dependents as being covered under the CVS/Caremark prescription drug program.

You and your covered dependents must present your medical ID card to the pharmacist, together with your prescription, whenever you need a prescription filled. You then pay the appropriate Copayment shown in the *"Summary of Medical Benefits."*

If you fail to show your ID card at a network pharmacy, or if the pharmacy cannot verify your eligibility, you must pay the pharmacy in full for the cost of your medication and then file a claim with CVS/Caremark for reimbursement. You will be responsible for the applicable Copayment plus the difference between the cost of any generic drug (available and approved by your physician) and any brand or non-formulary brand name drug that you purchased.

Through Mail Order

If you and/or your covered dependents need prescription medication on a regular or long-term basis, or more than a 30-day supply, you may order up to a 90-day supply (plus refills) through the CVS/Caremark mail order program. As shown in the *"Summary of Medical Benefits"* on page 33, you get 3 times the medication but only pay twice as much when you have your prescriptions filled through the CVS/Caremark mail order facility.

The mail order program saves money for both you and the Fund.

The Plan Does Not Cover Medications Filled at a Non-CVS/Caremark Mail Order Facility.

You can call CVS/Caremark at (888) 766-5519 or (800) 421-2342, or log onto its website at **www.caremark.com** to request mail order forms or to ask questions about the mail order program. When you receive the forms, fill out the mail service envelope and patient profile questionnaire and mail it with your prescription to the CVS/Caremark mail service pharmacy. You will receive your medication within 14 days.

Original Prescriptions. Ask your doctor to write you a prescription for up to a 90-day supply of medication (plus refills). The written prescription must include the following:

- Your (the patient's) full name and address;
- The prescribing doctor's name; and
- The quantity, strength and dosage of the medication.

If you are a Medicare-eligible retiree or the Medicare-eligible dependent of a retiree, you will continue to receive prescription benefits from this Plan only if you do NOT enroll in a Medicare prescription drug plan, known as a Part D plan. If you enroll in a Medicare prescription drug plan, you will lose prescription drug benefits under this Plan. If you enroll in a Medicare Part D plan and lose prescription drug coverage under this Plan, you cannot re-enroll in this Plan's prescription drug coverage in the future.

Refills. When ordering refills, place your order at least 3 weeks before the time your current supply runs out. If you call the CVS/Caremark mail order facility to order a refill, be ready to give the following information:

- Your (or the patient's) Social Security number and the number listed on your medical ID card;
- The prescription number (located in the box on the prescription and refill labels); and
- Your daytime phone number and area code.

Summary of Prescription Drug Benefits

Your prescription drug coverage is being provided in accordance with the following *"Summary of Prescription Drug Benefits:"*

SUMMARY OF PRESCRIPTION DRUG BENEFITS		
Service	**In-Network You Pay Per Prescription**	**Out-of-Network You Pay Per Prescription**
Generic Drugs	$5 retail/$10 mail order	Retail only: $5 plus balances over Allowed Amount
Formulary Brand Name Drugs	$20 retail/$40 mail order	Retail only: $20 plus balances over Allowed Amount
Non-Formulary Brand Name Drugs	$35 retail/$70 mail order	Retail only: $35 plus balances over Allowed Amount
ACA Preventive Drugs	$0 Copayment retail or mail order	Not covered
Retail Pharmacy Supply	30 days per prescription or refill	
Mail Order Maintenance Supply	90 days per prescription or refill	
Out-of-Pocket Maximum	$1,000 individual/$2,000 family	

Covered Medications and Supplies

The program covers drugs that are doctor-prescribed and approved by the Food and Drug Administration (FDA). Covered drugs and items include:

- Prescription contraceptives (birth control pills and other FDA-approved contraception for women);
- Needles and syringes;
- Insulin and diabetic supplies; and
- ACA-required preventive drugs.

ACA-Preventive Medications and Supplies

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

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

Non-Covered Medications and Supplies

Your prescription drug benefits do not cover the following:

- Drugs that, by law, do not require a prescription or are available over-the-counter, except insulin, self-administered injectables, and ACA-required preventive drugs. In order to receive reimbursement for over-the-counter drugs, you must have a prescription (except for insulin).
- Devices of any type (e.g., therapeutic devices, artificial appliances or similar devices), except where specifically covered.
- Vitamins, which by law do not require a prescription.
- Investigational or experimental drugs (i.e., medications used for experimental indications and/or dosage regimens determined as experimental, including drugs labeled "Caution-limited by Federal Law to Investigational Use") even though a charge is made to an individual.
- Compounded medications with no ingredients requiring a prescription order.
- Medications for cosmetic purposes only.
- Medications with no approved FDA indications, unless otherwise required by law (i.e., drugs that have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA).
- Replacement prescription medications resulting from loss, theft or breakage.
- The cost of medicine dispensed in excess of the contractual limitation.
- Drugs to treat infertility.
- Non-Federal legend (FDA-approved) drugs.
- Abortifacient drugs.
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine, Propecia) or for cosmetic purposes only (e.g., Renova, Vaniqa®).
- Medication for which the cost is recoverable under any workers' compensation or Occupational Disease Law or any state or governmental agency or medication furnished by any other drug or medical service for which no charge is made to the individual.
- Medication which is to be taken or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care Facility, skilled nursing Facility, convalescent Hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a Facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after 1 year from the physician's original order.
- Charges for the administration or injection of any drug.

Note the following:

- The amount of a drug that is to be dispensed per prescription or refill will be in quantities of up to a 30-day supply for retail and up to a 90-day supply for mail order.
- A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.

The Board of Trustees will review this list from time to time in light of new drugs approved by the FDA and other considerations and will revise the list of covered and non-covered drugs based on criteria established by CVS/Caremark. Please contact CVS/Caremark for the most up-to-date information on drugs not covered by the Plan.

The Plan's Creditable Coverage and Medicare Prescription Drug Plans

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The Board of Trustees has determined that the prescription drug coverage offered by the Local 14-14B Welfare Fund is, on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage, and is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a high premium (a penalty) if you later decide to join a Medicare drug plan.

If you are active or your spouse and you enroll in Medicare Part D your coverage will not be effected.

If you are retired, and you and/or your spouse enroll in a Medicare Part D plan, your (or your spouse's) prescription drug coverage under the Local 14-14B Welfare Fund will end. However, you will continue to be eligible for Medicare Supplemental Benefits. For more information, please refer to the Fund's Medicare Notice of Creditable Coverage (you may request a copy from the Fund Office).

Dental Benefits

The Plan is designed to help you pay for reasonably necessary dental care. Dental care coverage is available to active participants and their covered dependents (spouses and dependent children).

You may decline to receive dental benefits. Refer to the section entitled *"Enrolling for Coverage"* (page 8) for details.

Dental benefits are treated as a stand-alone (or excepted) benefit under the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act (PPACA).

You are advised that retirees are not covered for dental benefits.

How Eligible Dental Expenses Are Defined

To be considered an eligible dental expense, a dental service must meet the following criteria:

- It must be provided or performed by a dentist (or, for some treatments such as teeth cleaning, by a licensed dental hygienist working under the dentist's supervision).
- It must be for reasonably necessary dental care.
- It must be a covered expense.

Ineligible dental expenses not covered by the Plan are listed on page 63.

The Dental Provider Networks

Dental benefits, excluding orthodontia, are separately administered through Delta Dental under its DeltaPreferred network and its DeltaPremier network. For purposes of this Plan, DeltaPreferred's network dentists are defined as In-Network Providers; DeltaPremier's network dentists and non-participating dentists are defined as Out-of-Network Providers.

Orthodontia services for individuals (up to age 19) are provided and paid for by the Local 14-14B Welfare Fund, not through Delta Dental.

You have the option of choosing a participating dentist from either the DeltaPreferred network or the DeltaPremier network. The Delta Dental networks differ in size and cost.

- DeltaPremier has the largest dental network and pays a higher amount per procedure.
- DeltaPreferred has a smaller dental network and their dentists agree to accept less per procedure.

Keep in mind that, as a rule, the Plan covers only those services that are considered essential to good dental health. A list of covered dental expenses can be found on page 62.

How to Use the Dental Program

Using DeltaPreferred Dentists. The Local 14-14B Welfare Fund provides dental coverage through the DeltaPreferred dental program with a Point of Service option. Under this program, you have the freedom to visit any dental care Provider you like and still receive benefits for Covered Services. Just note, though, that you get the most savings when you receive your dental care from a DeltaPreferred network dentist.

When you receive care from a DeltaPreferred dentist (an In-Network Provider), the Plan pays 100% of your eligible dental expenses with no Deductible. All benefits are subject to Plan limits, as described later in this section.

For a directory of participating DeltaPreferred dentists in your area, go to **www.midatlanticdeltadental.com** or call (800) 932-0783 or TTY/TDD (888) 373-3582.

Using DeltaPremier and Non-Participating Dentists. When you use DeltaPreferred dentists, the dentists are paid directly by Delta Dental, and by agreement cannot bill the patient more than the applicable Copayments or Deductibles for the services provided. When you use a non-participating dentist, you will need to pay the dentist in full at each visit, and then follow the Plan's claims procedures. If a non-participating dentist charges you more than the Allowed Amount, you must pay the difference. For example, if the Allowed Amount for a routine checkup is $22 but your dentist charges you $125, you will be responsible for the $103 difference. Generally, it will cost you more out-of-pocket if you go to a DeltaPremier dentist instead of a DeltaPreferred dentist.

When you call to make an appointment with a non-participating DeltaPreferred dentist, please submit claim forms to: Delta Dental of New York (Group #1925) One Delta Drive Mechanicsburg, PA 17055

Maximum Dental Benefits. The maximum dental benefit the Plan pays is $1,500 per person or $4,500 per family in a calendar year (in- and out-of-network combined). This benefit maximum does not apply to individuals under age 19.

Dental Benefits When Alternate Procedures Are Available. Sometimes there are several ways to treat a dental problem, all of which provide acceptable results and are recognized by the profession as appropriate methods of treatment in accordance with broadly accepted national standards of dental practice. When alternate services or supplies can be used, the Plan will cover the least expensive services or supplies necessary to treat the condition. Of course, you and your dentist can still choose the costlier treatment method, in which case you would be responsible for any charges the Plan will not cover.

When a Predetermination is Required. If the cost of care to be provided to any patient is expected to exceed $300, Delta Dental recommends that you ask your dentist to submit the claim form in advance of treatment. Delta Dental will review the claim and return a predetermination to both you and the dentist indicating the services that are covered, how much of the proposed treatment will be paid by Delta Dental and how much will be your responsibility. Predetermination makes it easier to plan an appropriate course of treatment and it helps you by providing an advance breakdown of the coverages and charges.

Coverage for Orthodontia (For Children Under Age 19). Orthodontia services for covered dependents of active participants are provided and paid for by the Local 14-14B Welfare Fund and not through Delta Dental. The lifetime maximum benefit is $4,000 per individual under age 19. Benefits are paid in $200 increments for 20 consecutive months. Benefits under this Plan are limited to an active course of orthodontia treatment including diagnosis, evaluation, pre-care, initial installation of orthodontic appliances and adjustment of active orthodontia appliances. This orthodontia benefit is for non-surgical services provided to correct malocclusion (alignment of the teeth and/or jaws) and is paid when the dependent child is banded. Repair or replacement of orthodontia appliances is not covered. For more information, please contact the Fund Office.

Summary of Dental Benefits Through Delta Dental

The Plan offers dental coverage in accordance with the following *"Summary of Dental Benefits."*

SUMMARY OF DENTAL BENEFITS (DELTA DENTAL)		
Service	**In-Network (DeltaPreferred)**	**Out-of-Network (DeltaPremier and Non-Participating Providers); Subject to Deductible**
How You Access Care	Go to any DeltaPreferred network dentist who accepts the Local 14-14B Welfare Fund's fee schedule.	Go to any licensed/certified dentist in the DeltaPremier network or a non-participating dentist.
Annual Deductible	None	$50 per person $100 per family
Annual Maximum Benefit	$1,500 per person or $4,500 per family per calendar year	
	Diagnostic, Preventive and Other Services	
Diagnostic Services (exam and x-ray)	100%	100% of allowance
Preventive Services (cleaning teeth, children and adult fluoride treatments to age 19 and sealants to age 14)	100%	100% of allowance
Basic Restorative (fillings)	50%	50% of allowance
Major Restorative (crowns)	50%	50% of allowance
Oral Surgery (extractions)	50%	50% of allowance
Endodontics (root canal therapy)	50%	50% of allowance
Periodontics (treatment of gum disorders)	50%	50% of allowance
Prosthodontics (dentures, bridgework)	50%	50% of allowance

Non-Covered Dental Services

The following is a partial list of services not covered under the Delta Dental program:

- Services provided or devices started prior to the effective date of the Plan.
- Prescription drugs.
- Pre-medications.
- Relative analgesia.
- General anesthesia, except with oral surgery.
- Charges for hospitalization, including Hospital visits.
- Plaque control programs, including oral hygiene and dietary instruction.
- Procedures to correct congenital or developmental malformations, except for children eligible at birth.
- Procedures, appliances or restorations primarily for cosmetic purposes.
- Increasing vertical dimension.
- Replacing tooth structure lost by attrition.
- Periodontal splinting.
- Gnathological recordings.
- Equilibration.
- Implants.
- TMJ (temporomandibular joint dysfunction) treatment.
- Custom made mouth guards.

Contact the Fund Office for a full list of limitations and exclusions.

Optical Benefits

Vision care plays an important role in your overall health. Therefore, the Local 14-14B Welfare Fund provides optical benefits through General Vision Services (GVS) and Vision Screening.

Optical benefits are treated as a stand-alone (or excepted) benefit under the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act (PPACA). You may decline to receive optical benefits. Refer to the section entitled *"Enrolling for Coverage"* for details.

To obtain a voucher, a list of GVS offices and information on Vision Screening, call the Fund Office. For GVS Member Office locations, call (800) VISION-1.

The Provider Networks

You and your dependents can receive certain optical benefits at no cost once every 24 months if you obtain services through GVS (or its Member Offices) or Vision Screening. GVS Member Offices are independent doctors who contract with GVS and Vision Screening to provide vision services to you and your eligible dependents if you reside outside the New York metropolitan area.

If you choose not to use either GVS or Vision Screening, you can still receive optical benefits. The Local 14-14B Welfare Fund reimburses up to $250 every 24 months for any eligible out-of-network expenses you incur.

Covered Optical Expenses

Once every 24 months, you and each of your covered dependents are entitled to the following optical expenses through GVS or Vision Screening:

If you do not use a GVS or Vision Screening Provider, the Fund still pays up to a maximum of $250 every 24 months for eligible optical expenses.

- A comprehensive eye examination, including cataract and glaucoma screening. For eligible dependents, the Plan covers 1 eye examination every 24 months, up to the usual, customary and reasonable cost of such service. The $250 maximum does not apply.
- A complete pair of eyeglasses including frames from the GVS or Vision Screening collections, prescription plastic lenses (including single vision, bifocals, blended bifocals, trifocals, multifocals, hi-index (1.60), basic progressive, safety, oversize and cataract lenses), cosmetic tints, Rx sunglass tints, UV coating, scratch resistant and anti-reflective coatings.
- Standard soft daily wear and extended wear contact lenses (in lieu of glasses) or basic disposable contact lenses, up to a $250 maximum for 6 boxes, including fitting fee and unlimited follow-up exams for 1 year. Colored contact lenses are not included.

Coverage For Laser Vision Surgery

The Local 14-14B Welfare Fund pays your eligible expenses for laser vision surgery (sometimes referred to as Lasik), up to a lifetime maximum benefit of $500 per eye.

Non-Covered Optical Expenses

The following optical products and services are ineligible expenses under the Plan:

- Expenses incurred for ophthalmic treatment or services payable under the provisions of any other benefit of the Plan.
- Non-prescription eyeglasses.
- Adornment expenses.

Adoption Benefit

This Plan provides an adoption allowance to active participants of up to $5,000 for each legally adopted minor child.

This adoption allowance is not available when the child is a stepchild of, or related by blood to, the participant or the participant's spouse.

All claims must be submitted to the Fund Office within 6 months of the adoption being finalized. Your claim must include a copy of the certified court order (signed by a judge) as proof of adoption and a certified copy of the child's birth certificate.

Contact the Fund Office for more details.

For information about the Plan's adoption allowance, contact the Fund Office at (718) 939-1489.

Weekly Loss of Time Benefit

The Local 14-14B Welfare Fund provides a Weekly Loss of Time Benefit (i.e., Short Term Disability benefits) for active participants only. Dependent children and spouses are not eligible for these benefits.

These benefits provide up to 26 weeks of income for active participants who are unable to work due to a non-work-related injury or illness (including disability due to pregnancy). **Benefits are not paid for accidents or illnesses arising out of or in the course of your employment.**

You do not have to pay for these benefits. They are paid for entirely by Contributing Employer contributions and they are guaranteed to be at least the same amount and duration as those payable under New Jersey and New York disability laws.

Disability Benefits For Participants/Employees Who Are Employed by Employers Located in New York

Eligibility For Disability Benefits. You are eligible for the Weekly Loss of Time Benefit after completing at least 4 weeks of work in Covered Employment immediately prior to the disability. To be eligible for the Weekly Loss of Time Benefit, you must meet the following requirements:

- You are unable to work due to either a non-occupational accidental bodily injury or a non-occupational illness and you are not performing any kind of work for wages, remuneration or profit.
- You are under the care of a physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice during the entire course of the disability.
- You are not eligible for benefits under Workers' Compensation or any similar law.

Disability benefits are not payable for Dependents and/or spouses.

Period of Disability. Weekly statutory benefits, in the amount of $350 per week (minus FICA), are payable for any non-work related injury or illness (including disability due to pregnancy). Benefits are payable from the eighth day of disability. Payment will continue up to a maximum of 26 weeks of benefits during a period of 52 consecutive weeks or during any 1 period of disability that starts with the first week of benefits. Successive periods of disability separated by less than 2 consecutive weeks of full-time active work are considered one continuous period of disability. You will only receive weekly disability benefits for 2 disability periods if your second disability is due to an injury or sickness entirely unrelated to the cause of your first disability and it begins 2 weeks after you returned to active work.

Exclusions/Limitations. Benefits are not payable for:

- More than 26 weeks during a period of 52 consecutive calendar weeks or during any 1 period of disability.
- Any period for which you are subject to suspension or disqualification of the accumulation of unemployment insurance benefit rights, or would be subject if you were eligible for such benefit rights, except for ineligibility resulting from your disability.
- Any disability due to any act of war, declared or undeclared.

- Any disability commencing before you become eligible for benefits under this Plan, but this will not preclude benefits for recurrence of a disability commencing prior to your eligibility.
- Any disability occasioned by the willful intention to bring about injury or illness upon yourself or another, or resulting from any injury or illness sustained in your perpetration of an illegal act.
- Any day of disability during which you performed work for remuneration or profit.
- Any period of disability during which you are not under the care of:
  - A duly licensed physician;
  - A duly registered and licensed podiatrist of the State of New York;
  - A duly registered and licensed chiropractor of the State of New York;
  - A duly licensed dentist of the State of New York;
  - A duly registered and licensed psychologist of the State of New York;
  - A duly certified nurse midwife; or
  - A practitioner duly accredited by a church or denomination to perform prayer or faith healing; and

  Provided you submit to all required physical examinations.
- Any day of disability for which you are entitled to receive from your employer remuneration or maintenance in an amount equal to or greater than that to which you would be entitled under this Plan. However, any voluntary contribution or aid that an employer may make to you or any supplementary benefit paid to you pursuant to the provisions of a collective bargaining agreement or from a trust fund to which contributions are made pursuant to the provisions of a collective bargaining agreement, will not be considered as continued remuneration or maintenance for this purpose.

Non-Duplication of Benefits. No benefits will be payable under this Plan:

- For any week for which payments are received under the unemployment insurance law or similar law of this State or of any other State, or of the United States.
- For any period for which benefits, compensation or other allowances (other than worker's compensation benefits for a permanent partial disability occurring prior to the disability for which benefits are claimed under this Plan) are paid or payable under:
  - The New York State workers' compensation law or any other workers' compensation law, occupational disease law or similar law;
  - Any employers' liability law or similar law;
  - Any other temporary disability or cash sickness benefits law or similar law;
  - The Volunteer Firemen's Benefit Law;
  - Section 688, Title 46, United States Code;
  - The Federal Employers' Liability Act; or
  - The Maritime Doctrine of Maintenance, Wages and Cure.

Period of Disability. You must file a claim for the Weekly Loss of Time Benefit within 30 days of the start of your disability (unless you can prove that it was not reasonably possible for you to do so within this time period). If your application for weekly accident and sickness benefits is denied, you can appeal that decision to the Board of Trustees, or the Workers' Compensation Board by writing to:

Workers' Compensation Board
District Office Location
Riverview Center
150 Broadway, Suite 195
Menands, NY 12204

You must make your appeal within 1 year of the date of the decision.

Disability Benefits For Participants/Employees Who Are Employed by Employers Located in New Jersey

If your disability is due to illness, your Weekly Loss of Time Benefit begins on the eighth day of disability. After you have received disability payments for 3 consecutive weeks, the State of New Jersey Disability Benefits Law allows you to receive payment for the first 7 days of your disability.

Period of Disability. The State of New Jersey defines "a period of disability" as the entire period of time during which you are continuously and totally unable to perform the duties of your employment. Under this definition, if you have 2 periods of disability due to the same or related cause or condition and separated by a period of not more than 14 days, they will be considered as 1 continuous period of disability, provided you have earned wages during such 14-day period with the employer who was your last employer immediately preceding the first period of disability.

Exclusions/Limitations. The following exclusions and limitations apply under the Plan. Benefits are not payable under this Plan:

- For the first 7 consecutive days of each period of disability, except that if benefits are payable for 3 consecutive weeks for any period of disability, then benefits will also be payable with respect to the first 7 days.
- For more than 26 weeks for any 1 period of disability.
- For any period of disability that did not commence while you were a "covered individual" (i.e., a person who is in "employment" as defined by the New Jersey Unemployment Compensation Law for which you are entitled to remuneration from an employer covered by such Law, or a person who has been out of such employment for less than 2 weeks).
- For any period during which you are not under the care of a legally licensed physician, dentist, optometrist, podiatrist, practicing psychologist, advanced practice nurse or chiropractor, who when requested by the Plan or the New Jersey Division of Temporary Disability Insurance, will certify within the scope of his/her practice, your disability, the probable duration thereof, and where applicable, the medical facts within his/her knowledge.

- For any period of disability due to willfully and intentionally self-inflicted injury, or to injury sustained in your perpetration of a crime of the first, second or third degree.
- For any period during which you perform any work for remuneration or profit.

Non-Duplication of Benefits Under New Jersey Law. The New Jersey Temporary Disability Benefits Law prohibits the payment of disability benefits:

- For any period during which benefits are paid or are payable under any unemployment compensation or similar law, or under any disability or cash illness benefit or similar law of this State or of any other State or Federal government.

  However, if disability benefits are paid or payable to you under the disability benefit law of another State, or under the Federal maritime law, you may still be eligible for New Jersey benefits. In this circumstance, your weekly benefit rate would be reduced by the amount paid concurrently under the other State or maritime law.

- For any period during which workers' compensation benefits are paid or payable, other than for permanent partial or permanent total disability previously incurred.
- Temporary disability benefits are reduced by the amount paid concurrently under any governmental or private retirement, pension or permanent disability benefit or allowance program to which a worker's most recent employer contributed on his/her behalf. However, please note that Social Security retirement benefits do not reduce State Plan temporary disability benefits.

Please contact the State of New Jersey Department of Labor and Workforce Development, P.O. Box 957, Trenton, New Jersey 08625 for more information regarding non-duplication of benefits provisions under the New Jersey Temporary Disability Benefits Law or to file an appeal. You may also appeal to the Board of Trustees.

Active participants that are unable to work due to non-work related disabilities may be eligible for up to 26 weeks of income.

Death Benefit

Be sure the Fund Office has your beneficiary designation on file. The beneficiary you designate to receive your Death Benefit will also be eligible to receive your Accidental Death and Dismemberment benefit, unless you choose otherwise.

How the Death Benefit Works

You are eligible for the Death Benefit while you are still working in Covered Employment and receiving active benefits. The Death Benefit is payable to your beneficiary. Pensioners who have retired with active coverage are also eligible for the Death Benefit.

Life insurance coverage, which is paid by the Local 14-14B Welfare Fund, is $35,000 for active participants and $7,500 for pensioners.

Naming a Beneficiary

Your Death Benefit beneficiary is the same as your Accidental Death and Dismemberment beneficiary, unless you choose otherwise.

If you do not name a beneficiary, or if your beneficiary dies before you and you have not named a new beneficiary, your Death Benefit will be paid to your surviving spouse, or if you do not leave a surviving spouse, then to your estate.

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

When Coverage Ends

An active participant's Death Benefit ends once he or she is no longer working in Covered Employment and no longer covered under the Local 14-14B Welfare Fund.

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

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

Claiming the Death Benefit

Your beneficiary must notify the Fund Office in writing of your death. The Fund Office will send your beneficiary the appropriate claim form necessary to receive these benefits from the Plan.

Accidental Death & Dismemberment (AD&D) Benefit

The Accidental Death & Dismemberment (AD&D) Benefit, which is paid for and administered by the Local 14-14B Welfare Fund, is in effect 24 hours a day. It is worldwide protection that applies to accidents while working in Covered Employment or off the job accidents at home or away from home. You are eligible while you work in Covered Employment and for 30 days after your active benefits expire.

How the AD&D Benefit Works

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

Your AD&D Benefit provides benefits to your beneficiary if you die, or to you if you are severely injured in an accident.

Summary of the AD&D Benefit

Loss	Benefit Payable
Life	$35,000
Both hands at or above the wrist; both feet at or above the ankle; eyesight in both eyes; or any combination of hand, foot and eyesight	$35,000
1 hand at or above the wrist; 1 foot at or above the ankle; or eyesight in 1 eye	$12,000
Thumb or index finger of either hand	$6,250

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

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

What's Not Covered

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

- Suicide or self-inflicted injury.
- Death or dismemberment that is not directly caused by an accidental injury.
- Non-commercial air travel.
- While you are working for an employer who is not required to contribute to this Plan on your behalf in a category of employment that would otherwise be considered Covered Employment under the terms of this Plan.

Accidental Death & Dismemberment Benefit for Job-Related Deaths

Each eligible participant of Local 14-14B will have up to $250,000 of insurance coverage in the event of a jobsite-related death or dismemberment that occurs while engaged in Covered Employment. To be eligible for this benefit, you must be eligible for Local 14-14B Welfare Fund benefits at the time of your death or dismemberment and engaged in Covered Employment. The benefit will be paid out as follows:

Loss	Benefit
Loss of Life	If the injury results in Loss of Life, the Accidental Death & Dismemberment Benefit for Job-Related Deaths will pay the Principal Sum ($250,000). Death must occur within 365 days of the accident.
Loss of Limb, Speech, Sight or Hearing	If the injury results in any of the following losses, the Accidental Death & Dismemberment Benefit for Job-Related Deaths will pay the benefit shown below. Loss must occur within 365 days of the accident.
Both hands or both feet	Principal Sum ($250,000)
One hand and one foot	Principal Sum ($250,000)
One hand or one foot plus the sight of one eye	Principal Sum ($250,000)
Sight of both eyes	Principal Sum ($250,000)
Speech and Hearing	Principal Sum ($250,000)
Speech or Hearing	½ Principal Sum ($125,000)
One hand, one foot, or sight of one eye	½ Principal Sum ($125,000)
Thumb and index finger of the same hand	¼ Principal Sum ($62,500)

Claiming the AD&D Benefit

If you die as the result of an accident, your beneficiary or family member should contact the Fund Office as soon as reasonably possible.

Generally, any claim payable under the Plan must be filed within 90 days after a loss is incurred. If you lose a hand, foot or sight in 1 eye as the result of an accident, you should contact the Fund Office within 13 weeks of the accident.

Notice of your loss should be sent to the Fund Office at:

International Union of Operating Engineers
Local 14-14B Welfare Fund
141-57 Northern Blvd.
Flushing, NY 11354

Submitting an accidental death claim is a little more complicated than a death benefit claim because you have to prove that the death was the result of an accident. If you submit a claim for dismemberment benefits, the Fund Office may require that you have a medical examination. The exam will be conducted by a doctor selected and paid for by the Local 14-14B Welfare Fund.

You or your beneficiary must submit the completed forms to the Fund Office along with proof of AD&D and any other requested information, and a copy of the death certificate if appropriate. See the section called *"Claims and Appeals"* for more information.

Claims and Appeals

Internal Claims and Appeals Procedures

This section describes the procedures followed by the Local 14-14B Welfare Fund in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for medical, dental, vision, prescription drug, disability, death and accidental death and dismemberment benefits.

The Plan's claims and appeal procedures apply to almost all claims that you incur.

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

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

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

General Information

Claims Administrator(s)

The Plan Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

Appropriate Claims Administrator	Types of Claims Processed
Claims Administrator for EPO Benefits (In-Network) – Empire Blue Cross Blue Shield	• Urgent, Concurrent and Pre-service Medical Claims • Medical Post-Service Claims
Claims Administrator for Out-of-Network Benefits – IUOE Local 14-14B Welfare Fund Office	• Out-of-Network Medical Post-Service Claims
Pharmacy Benefits Manager for Prescription Drug Benefits – CVS/Caremark	• Pre-service drugs • Post-Service Claims for out–of-network retail drugs
Dental Claims Administrator and PPO – Delta Dental	• DeltaPreferred and DeltaPremier PPO • Pre-Service Claims • Dental Post-Service Claims

Appropriate Claims Administrator	Types of Claims Processed
Optical Benefits Administrator and PPO – General Vision Services (GVS) – Vision Screening	• Participating Providers • Post-Service Optical Claims
IUOE Local 14-14B Welfare Fund Office	• Weekly Loss of Time (Short Term Disability) Claims • Self-Funded Death Benefits • Accidental Death and Dismemberment Claims

Days Defined

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

Discretionary Authority of Plan Administrator and Designees

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

Adverse Benefit Determination

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

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

Health Care Professional

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

All notices relating to external review will contain a notice about the availability of Spanish language services. Assistance with filing a claim for external review in Spanish is available by calling the customer service number found on your identification card or by calling the Fund Office at (718) 939-1489. Notices relating to external review will be provided in Spanish upon request.

SPANISH (Español): Para obtener asistencia en Español, llamar al número de servicio customer encontrado en su tarjeta de identificación o llame a la Oficina del Fondo al (718) 939-1489.

Definition of a Claim

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

Types of Claims

Health Benefit Claims

Health benefit claims can be filed for medical, dental, vision and prescription drug benefits.

There are 4 categories of health claims as described below:

- **Pre-Service Claims (Applicable to In-Network Medical Benefits)** – A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. Under this Plan, prior approval is required for in-network medical and prescription drug benefits.
- **Urgent Care Claims (Applicable to In-Network Medical Benefits)** – An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (ii) in the opinion of the claimant's attending health care Provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.
- **Concurrent Claims (Applicable to In-Network Medical Benefits)** – A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.
- **Post-Service Claims (Applicable to In-Network and Out-of-Network Medical, Dental, Vision, and Prescription Drug Benefits)** – A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Weekly Disability/STD Benefit Claims

A Weekly Disability/STD Claim is a request for benefits during a period of disability. Weekly Disability/STD Claims are filed after a participant suffers a disability and benefits are paid if the Claims Administrator determines that the participant has suffered a disability as defined by the terms of the Plan.

Death Benefit/Accidental Death and Dismemberment Claims

An Accidental Death and Dismemberment/Death Benefit Claim is a request by a designated beneficiary for benefit payment following the death of the participant. A claim for an Accidental Death and Dismemberment Benefit may also be filed by a participant after he or she has provided the Plan with proof of a bodily loss.

Claim Elements

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

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- Be received by the Plan Administrator or Claims Administrator (as applicable);
- Name a specific individual participant and his/her Social Security Number;
- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the Provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;

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

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

Initial Claim Decision Timeframes

Out-of-Network Claim Filing Deadline

Claims for out-of-network benefits should be filed within 6 months following the date charges were incurred. Failure to file claims within the time required will not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than 18 months from the date the charges were incurred.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered dependent, an authorized representative, or by a network Provider. In the event a claim is filed by a Provider, the Provider will not automatically be considered to be your authorized representative.

Health Care Claims – Decision Timeframes

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

- **Pre-Service Claims (Applicable to In-Network Medical Benefits)**

  Claims for Pre-Service (that are not for Urgent Care) will be decided no later than 15 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the initial 15-day period whether the claim was approved or denied (in whole or in part).

The time for deciding the claim may be extended by up to 15 days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, if applicable) notification before the expiration of the initial 15-day determination period.

If you improperly file a Pre-Service Claim, the Claims Administrator will notify you in writing (or electronically, as applicable) as soon as possible, but in no event later than 5 days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, you must re-file a claim to begin the Pre-Service Claim determination process.

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

- **Urgent Care Claims (Applicable to In-Network Medical Benefits)**

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

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

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

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

- **Concurrent Claims (Applicable to In-Network Medical Benefits)**

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

  A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section.

  A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

  If the Concurrent Care Claim is approved, you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.

  If the Concurrent Care Claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.

- **Post-Service Claims (Applicable to In-Network and Out-of-Network Medical, Dental, Vision and Prescription Drug Benefits)**

  Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part).

  The time for deciding the claim may be extended by 15 days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

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

Weekly Disability/STD Claims – Decision Timeframes

Claims for Weekly Disability/STD benefits will be decided no later than 45 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 45-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by 30 days due to circumstances beyond the Claim Administrator's control; provided you are given written (or electronic, as applicable) notification before the expiration of the initial 45-day determination period. A decision will be made within 30 days of the date the Claims Administrator notifies you of the delay. The period for making a decision may be delayed an additional 30 days if due to matters beyond the control of the Claims Administrator, provided you are notified of the additional delay, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

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

Accidental Death and Dismemberment or Death Benefit – Decision Timeframe

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

Initial Determinations of Benefit Claims

Notice of Adverse Benefit Determination

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

- Identify the claim involved (e.g., date of service, health care Provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (including a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal or external review);
- If the denial is based on a Plan standard that was used in denying the claim, provide a description of such standard;
- Reference the specific Plan provision(s) on which the denial is based;

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

Notice of Approval of Pre-Service and Urgent Care Claims

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

Internal Appeal Request Deadline

- **Health Care Claims (Applicable to Medical, Dental, Vision and Prescription Drug Benefits)**

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

- **Weekly Disability Claims**

  If an initial Weekly Disability Claim is denied and you disagree with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period.

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

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

Internal Appeals Process

Where to File Appeals

In-Network Empire EPO Benefits

Empire maintains a two-level appeal procedure. Empire breaks appeals into 2 categories, appeals and grievances, which they define as follows:

- An appeal is a request to review and change an Adverse Determination made when (i) Empire's Medical Management Program (MMP) or Mental and Behavioral Health Care Manager (MBHCM) determines a service is not Medically Necessary, or is excluded from coverage because it is considered Experimental or Investigational; or (ii) if Empire denies a claim, wholly or partly, for services already rendered, based on their utilization review process.
- A grievance is a verbal or written request for a review of an Adverse Determination concerning an administrative decision not related to medical necessity.

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

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

Send appeals concerning behavioral health care to:

Grievances and Appeals – Behavioral Health
P.O. Box 2100
North Haven, CT 06473

Urgent Care appeals may be made orally or in writing.

Dental Appeals

Delta Dental maintains a two-level appeal process. To file an internal appeal, you must submit a written statement to Delta Dental at the following address:

Delta Dental of New York
One Dental Drive
Mechanicsburg, PA 17055

Out-of-Network Medical, Prescription Drug, Optical, Weekly Loss of Time (Short-Term Disability), Death and Accidental Death and Dismemberment Claim Appeals

The Plan maintains a one-level appeal process for Medical, Prescription Drug, Optical, Weekly Loss of Time, Death and Accidental Death and Dismemberment Claims Appeals. To file an internal appeal, you or your authorized representative must submit a written statement to the Plan at the following address:

Board of Trustees
International Union of Operating Engineers
Local 14-14B Welfare Fund
Flushing, NY 11354
Phone: (718) 939-1489

Appeals Procedures

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

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

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

- Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
- The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

- **Health Care Claims**

Pre-Service/Concurrent Claims (Applicable to In-Network Medical Benefits).

For Empire EPO in-network appeals and grievances—Empire maintains a two-level appeal process. Empire will make the first level determination on the internal appeal or grievance of your initial Pre-Service Claim no later than 15 calendar days from the Plan's receipt of the appeal. You will be sent a written (or electronic, as applicable) notice of the appeal determination. If you are dissatisfied with the outcome of the Level 1 Appeal or Grievance, a Level 2 Appeal or Grievance may be filed with Empire within 60 business days from the receipt of the notice of the letter denying the Level 1 Appeal or Grievance. If the appeal is not submitted within that timeframe, Empire will not review it and the decision on the Level 1 appeal will stand. Appeals may be filed by telephone or in writing. A second level appeal determination will be made no later than 15 days from Empire's receipt of your request for a second level appeal review. No extension of the Plan's internal appeal review timeframes is permitted.

Urgent Care/Concurrent Claims/Expedited Appeal (Applicable to In-Network Medical Benefits).

Empire will speed up the appeal process (an "expedited appeal") and deliver a rapid decision when the situation involves:

i. Continuations or extensions of health care services, procedures or treatments already begun;

ii. Additional required or provided care during an ongoing course of treatment;

iii. A case in which the Provider believes an immediate appeal is warranted (e.g., the appeal is an Urgent Appeal); or

iv. When home health care is requested following discharge from an inpatient Hospital admission.

When requested under these circumstances, the following time frames will apply:

Empire will provide you or your Provider with reasonable access to the clinical reviewer within 1 business day of receiving a request for an expedited appeal. The Provider and clinical peer reviewer may exchange information by telephone, secure email or fax.

Empire will make a decision on an expedited appeal within the lesser of 72 hours of receipt of the appeal request or 2 business days following receipt of all necessary information about the case, but in any event within 72 hours of receipt of the appeal.

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

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

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

Post-Service Claims (Applicable to Out-of-Network Medical, Dental, Vision, and Prescription Drug Benefits).

Out-of-Network Medical, Vision and Prescription Drug Claims and Weekly Disability Claims: The Plan will make an appeal determination no later than the date of the Board of Trustees' meeting immediately following the Plan's receipt of your written request for an internal appeal, unless the request for an internal appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, an appeal determination will be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary, the Plan will provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Fund Manager/Board of Trustees will notify you in writing of the benefit determination no later than 5 calendar days after the benefit determination is made.

In-Network Empire EPO Appeals and Grievances: Empire who will make the first level determination on the appeal of your initial Post-Service Claim no later than 30 calendar days from their receipt of the appeal request. Empire will provide a written notice of the determination within 2 business days of reaching a decision. If Empire does not make a decision within 60 calendar days of receiving all necessary information to review your appeal, Empire will approve the service. If the first level appeal determination results in an adverse benefit determination, you will have 60 calendar days from your receipt of a notice of adverse benefit determination to request a second level appeal review by writing to Empire. Empire will then make a second level determination no later than 30 calendar days from its receipt of the second level appeal. You will then be provided with a written (or electronic, as applicable) notification of the second-level appeal determination no later than 30 days after Empire receipt of your request for a second level appeal.

Delta Dental Appeal: Delta Dental who will make the first level determination on the appeal of your initial Post-Service Claim no later than 30 calendar days from their receipt of the appeal request. Within this 30-day period, you will be sent a written (or electronic, as appropriate) notice of the appeal determination. If the first level appeal determination results in an adverse benefit determination, you will have 180 calendar days from your receipt of a notice of adverse benefit determination to request a second level appeal review by writing to Delta Dental. Delta Dental will then make a second level determination no later than 30 calendar days from its receipt of the second level appeal. You will then be provided with a written (or electronic, as applicable) notification of the second-level appeal determination no later than 30 days after Delta Dental's receipt of your request for a second level appeal.

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

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

Notice of Adverse Benefit Determination Upon Appeal

A written (or electronic, as applicable) notice of the appeal determination must be provided to you that includes:

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

This concludes the provisions of the appeal process followed by this Plan. The Plan does not offer a voluntary appeal process.

Authorized Representative

The Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file an initial claim and appeal an adverse benefit determination under the Plan. An authorized representative under the Plan also includes a health care professional. You do not need to designate in writing that the health care professional is your authorized representative if that health care professional is part of the claim appeal. A health care Provider with knowledge of your medical condition may act as your authorized representative in connection with an Urgent Care Claim without filing a written statement with the Plan.

The Plan requires you to provide a written statement declaring your designation of an authorized representative except for a health care professional who does not require a written statement in order to appeal a claim for a claimant) along with the representative's name, address, phone number and email address. To designate an authorized representative, you must submit a completed authorized representative form (available from the appropriate Claims Administrator/Plan Administrator). If you are unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (e.g. notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is your legal spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an authorized representative form, all future claims and appeals-related correspondence will be routed to the authorized representative rather than to you. The Plan will honor the designated authorized representative for 1 year before requiring a new authorization/until the designation is revoked, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from, and to be returned to, the appropriate Claims Administrator/Plan Administrator.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

Limitation on When a Lawsuit May Be Started

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

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

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

Elimination of Conflict of Interest

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

Facility of Payment

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan

may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator/Board of Trustees/Other Fiduciary, appropriate Claims Administrator nor any other designee of the Plan will be required to see to the application of the money so paid.

External Review of Claims

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization (IRO). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

All notices relating to external review sent will contain a notice about the availability of Spanish language services. Assistance with filing a claim for external review in Spanish is available by calling the customer service number found on your identification card or by calling the Fund Office at (718) 939-1489. Notices relating to external review will be provided in Spanish upon request.

SPANISH (Español): Para obtener asistencia en Español, llamar al número de servicio customer encontrado en su tarjeta de identificación o llame a la Oficina del Fondo al (718) 939-1489.

Claims Eligible for the External Review Process

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

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment; and/or
- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible for the External Review Process

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

- Claims that involve only contractual or legal interpretation without any use of medical judgment, including grievances about Allowed Amounts payable under the Plan;
- A determination that you or your dependent is not eligible for coverage under the terms of the Plan;
- Claims that are untimely, meaning you did not request review within the 4-month deadline for requesting external review;

- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies); and
- Claims that relate to benefits other than health care benefits (such as disability benefits, death benefits, and dental/vision benefits that are considered excepted benefits).

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

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

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

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

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

To begin the standard external review process, do the following:

- **For Empire EPO (In-Network) Claims**

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

- **For Out-of-Network Medical and Prescription Drug Claims**

All requests for out-of-network Medical and Prescription Drug claims, must be sent in writing to the Fund Office at 141-57 Northern Boulevard, Flushing, NY 11354.

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

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

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

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

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

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

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

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

- The IRO will timely notify you in writing that your request is accepted for external review.
- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within 10 business days. The IRO is not required to, but may, accept and consider additional information you submit after the 10-business-day deadline.
- Within 5 business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.

- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within 1 business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If the Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within 1 business day. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo*, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care and effectiveness of a covered benefit.
- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care Providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

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

Expedited External Review of an Urgent Care Claim

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

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

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

- **For Empire EPO (In-Network) Benefits**

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

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

- **Out-of-Network Medical and Prescription Drug Claims**

  All requests for out-of-network Medical and Prescription Drug claims should be sent in writing to the Fund Office at 141-57 Northern Boulevard, Flushing, NY 11354.

Preliminary Review of an Urgent Care Claim by the Plan

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

Review of an Urgent Care Claim by the IRO

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

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

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

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

What Happens After the IRO Decision is Made?

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

Other Information You Should Know

The Plan's Website

All participants have access to a password-protected website to learn about all of the IUOE Local 14-14B Fringe Benefit Funds. The website address is **www.local14funds.org**.

If you are covered under more than one health care plan, this Plan's coordination of benefits (COB) rules will apply.

Coordination of Benefits

Since it is possible you and/or your dependents may be covered by more than one health care plan, the Plan contains a coordination of benefits (COB) feature. This allows provisions of 2 or more plans to be considered when determining benefits. You may still receive up to 100% (but not more) of billed charges (or applicable reasonable and customary charges) covered by at least one of the plans.

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

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

Effects of Coordination

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

Which Plan Pays First: Order of Benefit Determination Rules

The Overriding Rules

This Plan does not coordinate benefits with an individual plan, including a plan purchased through the Health Insurance Marketplace. Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first**.

When 2 group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

Transferring Members. For transferring union members, the other local union's coverage will be primary and the Local 14-14B Welfare Fund coverage will be secondary until primary coverage is exhausted. Contact your local Fund Administrator for more details.

These rules are:

Rule 1: Non-Dependent or Dependent

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

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

Rule 2: Dependent Child Covered Under More Than One Plan

1. The plan that covers the parent whose Birthday falls earlier in the calendar year pays first; and the Plan that covers the parent whose Birthday falls later in the calendar year pays second, if:

   a. the parents are married;

   b. the parents are not separated (whether or not they ever have been married); or

   c. a court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.

2. If both parents have the same Birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

3. The word "Birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

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

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

5. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

   a. The plan of the custodial parent pays first; and

   b. The plan of the spouse of the custodial parent pays second; and

   c. The plan of the non-custodial parent pays third; and

   d. The plan of the spouse of the non-custodial parent pays last.

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

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

1. The plan that covers a person either as an active participant (that is, a participant who is neither laid-off nor retired), or as that active participant's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

3. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active participant under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

1. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, participant or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

3. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, participant or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active participant under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

1. If none of the 4 previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

2. To determine how long a person was covered by a plan, 2 plans are treated as 1 if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

3. The start of a new plan does not include a change:

   a. in the amount or scope of a plan's benefits;

   b. in the entity that pays, provides or administers the plan; or

   c. from one type of plan to another (such as from a single employer plan to a multiple employer plan).

4. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a participant of the group will be used to determine the length of time that person was covered under the plan presently in force.

Rule 6: When No Rule Determines the Primary Plan

If none of the previous rules determines which plan pays first, each plan will pay an equal share of the expenses incurred by the covered individual.

How Much This Plan Pays When It Is Secondary:

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

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

- The difference between the cost of a semi-private room in a Hospital or Health Care Facility and a private room, unless the patient's stay in a private Hospital room is determined (by the Plan Administrator it is designee) to be Medically Necessary.
- If the coordinating plans determine benefits on the basis of an Allowed Charge amount, any amount in excess of the highest Allowed Charge is not an allowable expense.
- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.

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

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

Administration of Coordination of Benefits (COB)

To administer COB, the Plan reserves the right to:

a. exchange information with other plans involved in paying claims;

b. require that you or your Health Care Provider furnish any necessary information;

c. reimburse any plan that made payments this Plan should have made; or

d. recover any overpayment from your Hospital, physician, dentist, other Health Care Provider, other insurance company, you or your Dependent

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

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

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

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

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

Coordination with Government and Other Programs

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

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

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

Motor Vehicle Coverage Required by Law: If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second. This Plan's benefit coverage is excess to any vehicle insurance (including medical payments coverage/MVC, personal injury protection/PIP and/or no-fault).

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

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

About Medicare Coverage

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

- **Medical Participants Who Retain or Cancel Coverage Under This Plan**

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

If you choose to cancel your coverage under this Plan, coverage for your spouse and/or dependent child(ren) will terminate, but they may be entitled to COBRA continuation coverage. Please refer to page 20 for further information about how to obtain COBRA continuation coverage.

- **Coverage Under This Plan and Medicare When You Are Totally Disabled**

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

- **Coverage Under This Plan and Medicare When You Have End-Stage Renal Disease**

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

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

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

- **Coverage Under Medicare For Pensioners and Their Dependents**

  If a pensioner is not actively working (e.g., retired) and is covered by Parts A and B or Part C as well as this Plan, Medicare pays first and this Plan pays second.

  If a pensioner under this Plan is covered by Medicare and cancels (opts out or drops) coverage under this Plan, coverage for his/her dependent(s) will terminate, but they may be entitled to COBRA continuation coverage. See the *"Continuation of Coverage"* section for further information about COBRA continuation coverage. If any of the dependents are covered by Medicare and the pensioner cancels a dependent's coverage under this Plan, that dependent will not be entitled to COBRA continuation coverage. The choice of retaining or canceling a Medicare-covered beneficiary's coverage under this Plan is your (the pensioner's) responsibility.

- **How Much This Plan Pays When It Is Secondary to Medicare**

  When Covered by Medicare Parts A or B: When a pensioner or dependent of a pensioner is covered by Medicare Parts A and B, this Plan will be secondary to Medicare. In such cases, this Plan pays the Part A Deductible and Coinsurance and the Part B Deductible and Coinsurance amounts not payable by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the usual and customary charges of the health care Provider.

  When Covered by Medicare Part D: If an eligible participant or eligible dependent enrolls in a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Plan with prescription drug coverage (MA-PD), prescription drug coverage **will be terminated** and he/she will not be eligible to receive benefits for any prescription drug benefits under this Plan. However, medical benefits will continue.

- **Why You Enter Into a Medicare Private Contract**

  Under the law, a Medicare beneficiary is entitled to enter into a Medicare private contract with certain health care Providers under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Provider. If you or an eligible dependent enters into such a contract, this Plan will not pay any benefits for any health care services and/or supplies you receive pursuant to it.

- **Enrolling in Medicare**

  It is important that you or your eligible dependent visit an office of the Social Security Administration during the three-month period prior to your 65th birthday to learn all about Medicare. For questions about coverage by this Plan, or help in comparing benefits offered by this Plan and Medicare, please contact the Fund Office. **Remember, this Plan only pays benefits that are secondary to Medicare so if you do not enroll in Medicare Parts A and B, your benefits will be reduced.**

Subrogation and Reimbursement

Although no benefits are payable under the Local 14-14B Welfare Fund for medical expenses, disability income benefits or any other benefit (except the death benefit) that is included or includable by any claim or lawsuit instituted by a covered participant and/or covered dependent against any third party, the Local 14-14B Welfare Fund may advance payment on account of Plan benefits subject to its right to be reimbursed by the participant and/or dependent for the full amount of such advance payment if and when there is any recovery from any third party. By accepting such an advance, the covered participant and/or covered dependent agree that the Plan will be subrogated to the covered participant and/or covered dependent's right of recovery from a third party or that third party's insurer for the entire amount advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule.

The right of reimbursement will apply:

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

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

Cooperation With the Plan By All Covered Individuals. By accepting an advance, regardless of whether or not an agreement has been executed, the covered participant and/or covered dependent agrees:

- To reimburse the Plan for all amounts paid or payable to the covered participant and/or covered dependents or that third party's insurer for the entire amount advanced.
- That the Plan has the first right of reimbursement from any judgment or settlement.
- To do nothing that will waive, compromise, diminish, release or otherwise prejudice the Plan's reimbursement and subrogation rights.
- To not assign the right of recovery to any third party without the specific consent of the Plan.
- To notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party alleged to be responsible for the injury or illness that resulted in the advance, or entering into any settlement agreement with that third party or third party's insurer based on those acts.
- To inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

Confidentiality of Your Health Care Information

The Plan is required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

Effective April 14, 2003, HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans, such as the Local 14-14B Welfare Fund (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

- The term **"Protected Health Information"** (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- PHI does not include health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical Leave, etc.

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

The Plan and the Plan Sponsor, the Board of Trustees of the Local 14-14B Welfare Fund, will not use or further disclose PHI except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

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

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

- **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care Providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.
- **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

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

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

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

- **Health Care Operations** includes, but is not limited to:

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

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

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

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

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

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

B. When an Authorization Form is Needed. Generally, the Plan will require that you sign a valid authorization form (available from the Fund Office) in order for the Plan to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

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

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;
2. Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;
3. Not use or disclose the information for employment-related actions and decisions;
4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);
5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

7. Make PHI available to the individual in accordance with the access requirements of HIPAA;
8. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
9. Make available the information required to provide an accounting of PHI disclosures;
10. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;
11. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
12. If a breach of your unsecured PHI occurs, the Plan will notify you.

D. In Order to Ensure That Adequate Separation Between the Plan and the Plan Sponsor is Maintained in accordance with HIPAA, only the following participants or classes of participants may be given access to use and disclose PHI:

1. The Plan Administrator;
2. Staff designated by the Plan Administrator; and
3. Business Associates under contract to the Plan.

E. The Persons Described in Section D Above May Only Have Access to and Use and Disclose PHI For Plan Administration Functions That the Plan Sponsor Performs For the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer.

F. Effective April 21, 2005, and in Compliance With HIPAA Security Regulations, the Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan;
2. Ensure that the adequate separation discussed in Section D above, specific to electronic PHI, is supported by reasonable and appropriate security measures;
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

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

How Benefits May Be Reduced, Delayed or Lost

There are certain situations under which benefits may be reduced, delayed or lost. Most of these circumstances are explained in the previous sections, but your benefits and those of your covered dependent will also be affected in the event either of you:

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

You should also be aware that benefits are not payable for enrolled dependents who become ineligible due to age, marriage or divorce (unless they elect and pay for COBRA continuation coverage, as described on page 20).

If this Plan mistakenly pays a larger benefit than you are eligible for, or pays benefits that were not authorized by this Plan, this Plan may seek any permissible remedy allowed by law to recover benefits paid in error (please refer to the section of this booklet entitled *"Subrogation and Reimbursement,"* page 101).

Providing the Information Required

You must furnish to the Board of Trustees all such information in writing as may be reasonably requested for the purpose of establishing, maintaining and administering the Fund. Failure on your part to comply with such requests promptly and in good faith will be sufficient grounds for delaying payment of benefits. The Board of Trustees will be the sole judge of the standard of proof required in any case, and from time to time may adopt such formulas, methods and procedures as the Board considers advisable.

The Importance of Providing Your Mailing Address

In the event that you fail to inform the Board of Trustees of a change of address and the Board is therefore unable to communicate with you at the address last recorded and a letter sent by first class mail to you is returned, payments due to you will be held without interest until payment is successfully made.

If You Divorce

If you and your spouse get a divorce, your spouse will no longer be eligible for coverage under the Plan. If the Trustees pay benefits to you that exceed the amount of benefits that should be paid under the terms of this Plan, the Trustees will have the right, to the greatest extent allowed by law, to recover the wrongfully paid benefits. Once your spouse is no longer eligible for coverage under the Plan, he or she may elect to continue coverage under COBRA for up to 36 months. You or your spouse **must** notify the Fund Office within 30 days of the divorce date in order for your spouse to elect and receive COBRA continuation coverage. At that time, you may also want to review your beneficiary designation for your Death Benefit and AD&D benefits, if eligible.

Your Rights Under ERISA

As a participant in the International Union of Operating Engineers Local 14-14B Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to the following.

Receive Information About Your Plan and Benefits

- 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, collective bargaining agreements, and the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and the updated Plan Document and Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- 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.

Read this section carefully so that you fully understand your rights under ERISA.

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance With Your Questions

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

National Office:

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

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

Plan Facts

Official Plan Name	International Union of Operating Engineers Local 14-14B Welfare Fund
Employer Identification Number	11-2392159
Plan Number	501
Plan Year	July 1 – June 30
Board of Trustees/ Fund Administrator	**Union Trustees** Edwin L. Christian IUOE Local 14-14B 141-57 Northern Boulevard Flushing, NY 11354 Christopher T. Confrey IUOE Local 14-14B 141-57 Northern Boulevard Flushing, NY 11354 John Cronin IUOE Local 14-14B 141-57 Northern Boulevard Flushing, NY 11354 Kenneth Klemens, Jr. IUOE Local 14-14B 141-57 Northern Boulevard Flushing, NY 11354 **Employer Trustees** Donald DeNardo Contractors' Association of Greater New York, Inc. 200 Park Avenue, 9th Floor New York, NY 10168 John F. O'Hare Building Contractors Association 451 Park Avenue South, 4th Floor New York, NY 10016 Denise M. Richardson The General Contractors Association of New York, Inc. 60 East 42nd Street, Room 3510 New York, NY 10165 Ernesto Tersigni The Cement League 49 West 45th Street, Suite 900 New York, NY 10036
Fund Manager	Marlene Monterroso 141-57 Northern Boulevard Flushing, NY 11354 Telephone: (718) 939-1489
Agent for Service of Legal Process	Legal process may be served on the Plan or on any member of the Board of Trustees at the address listed below. The Board of Trustees for the International Union of Operating Engineers Local 14-14B Pension Fund 141-57 Northern Boulevard Flushing, NY 11354

Type of Plan	This Plan is an employee welfare benefit plan that provides medical, prescription drug, dental, vision, weekly loss of time (short-term disability), death, accidental death and dismemberment benefits and adoption benefits. • The Fund self-insures and administers out-of-network medical, orthodontic, weekly loss of time (short-term disability), adoption, death and AD&D benefits. • In-network medical and Hospital benefits are self-insured and administered by Empire Blue Cross Blue Shield in accordance with Empire Blue Cross Blue Shield's policy terms, conditions, limitations and exclusions. If a difference exists between the information in this SPD about your in-network medical and Hospital benefits and Empire's Certificate of Coverage, the Certificate of Coverage will govern. • The Dental PPO is self-insured and administered by Delta Dental. • The prescription drug benefit is self-insured and administered by CVS/Caremark. • The in-network optical benefit is self-insured and administered by General Vision Services and/or Vision Screening.
The Plan's Compliance With Federal Law	The Plan is governed by regulations and rulings of the Internal Revenue Service and the Department of Labor and current Federal tax law. The Plan will always be construed to comply with these regulations, rulings and laws.
Provider Non-Discrimination	With respect to participation under the Plan or the Plan's coverage, the Plan will not discriminate against any health care Provider who is acting within the scope of his or her license or certification under applicable state law.
Amendment and Termination of the Plan	The Trustees of the Fund have the authority to amend or terminate the Plan at any time and for any reason. You will be notified if the Plan is amended or terminated; however, the change may be effective before a notice is delivered to you. If the Plan is ended, Plan assets will be applied to provide benefits in accordance with the applicable provisions of Federal law.
Your Disclosures to the Plan	If you provide false information to the Plan or commit fraud, you will be required to indemnify and repay the Plan for any losses or damages caused by your false statements or fraudulent actions. (Some examples of fraud include altering a check and knowingly cashing a voided check.) What's more, if the Plan makes payments as a result of false statements or fraudulent actions, the Board of Trustees may elect to pursue the matter by pressing criminal charges.
Plan Administration	Fund assets are accumulated under the provisions of a Trust Agreement and are held in a Trust Fund for the purpose of providing benefits to participants and defraying reasonable administrative expenses. The Fund is administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees. The Fund's assets and reserves are invested by various investment advisors.

The Discretionary Authority of the Board of Trustees	The Board of Trustees governs the Fund in accordance with an Agreement and Declaration of Trust. The Trustees have the sole and absolute discretionary authority to interpret the terms of the Plan, determine benefit eligibility and resolve ambiguities or inconsistencies in the Plan. All determinations and interpretations made by the Board of Trustees and/or its duly authorized designee(s) will be final and binding upon all participants, beneficiaries and any other individuals claiming benefits under the Plan. The Board of Trustees has delegated certain administrative and operational functions to the Fund Manager and his/her staff. Most of your day-to-day questions can be answered by the Fund Office staff.
Collective Bargaining Agreements/Employer Contributions	Benefits are provided pursuant to collective bargaining agreements. The Fund receives contributions according to collective bargaining agreements between your employer and Local 14-14B. These collective bargaining agreements provide that employers contribute to the Fund on behalf of each covered participant on a specified basis. Certain other employers (such as the Union and Fund Office) may participate in the Plan by signing a participation agreement. To find out whether a particular employer is contributing to the Fund on behalf of participants working under a collective bargaining agreement or a participation agreement and, if so, to which plan of benefits the employer is contributing, contact the Fund Office. You can look at the collective bargaining agreements at the Fund Office or get your own copy upon written request to the Fund Office. The Fund Office will also provide you with, upon written request, a list of Contributing Employers.
No Liability For the Practice of Medicine or Dentistry	The Plan, the Trustees and their designees **are not** engaged in the practice of medicine or dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care Provider. Neither the Plan, the Trustees, nor any of their designees will have any liability whatsoever for any loss or injury caused to you by any health care Provider by reason of negligence, by failure to provide care or treatment or otherwise.
The Plan's Right to Offset	In the event any payment is made by the Plan to an individual who is not entitled to payment, the Plan shall have the right to reduce future payments payable to such individual by the amount of any erroneous payment. This right of offset, however, shall not limit the right of the Plan to recover overpayments in any other manner.
Facility of Payment	If the Plan Administrator or its designee determines that you cannot submit a claim or proof that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, Claim Administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

Glossary

Refer to these definitions to help you better understand your Plan coverage:

Adverse Determination

A communication from the Plan or Empire's Medical Management that reduces or denies benefits in whole or part.

Allowed Charge/Allowed Amount/Maximum Allowed Amount

With respect to a Network Provider, the term "Allowed Charge," "Allowed Amount" or "Maximum Allowed Amount" means the negotiated fee or rate set forth in the agreement between the participating In-Network Provider or Facility and the network or the Plan.

With respect to an Out-of-Network Provider, the term "Allowed Charge," "Allowed Amount" or "Maximum Allowed Amount" means the maximum dollar amount the Plan has determined it will allow for Medically Necessary Covered Services and supplies.

The Plan will not always pay benefits equal to or based on the health care or dental care provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, Copayment and/or Coinsurance. This is because the Plan covers only the Allowed Charge/Allowed Amount/Maximum Allowed Amount for health care services or supplies.

The Plan's Allowed Charge/Allowed Amount/Maximum Allowed Amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary; reasonable and customary; usual, customary and reasonable charge; prevailing; or by any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim.

Any amount in excess of the Allowed Charge/Allowed Amount/Maximum Allowed Amount does not count toward the Plan's annual maximum out-of-pocket costs. Participants are responsible for amounts that exceed Allowed Charge/Allowed Amount/Maximum Allowed Amounts by this Plan.

The Plan reserves the right to negotiate with an Out-of-Network Provider to reduce its billed charges to a lower discounted amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a utilization management company, claims administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the Allowed Charge/Allowed Amount/Maximum Allowed Amount upon which the Plan will base its payment for Covered Services for the Out-of-Network Provider considering the Plan's cost-sharing provisions, In-Network/Out-of-Network plan design, and any special reimbursement provisions adopted by the Plan.

In accordance with federal law, with respect to emergency services performed in an Out-of-Network Emergency Room (ER), the Plan's allowance for ER visit Facility fees and ER professional fees is to pay the **greater** of:

a. the negotiated amount for In-Network Providers (the median amount if more than one amount for In-Network Providers);

b. 100% of the Plan's usual payment (Allowed Charge) formula (reduced for cost-sharing); or

c. when such a database is available, the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

Ambulatory Surgery

See "same-day surgery."

Annual Out-of-Pocket Limit

The most you pay during a calendar year in cost sharing before your Plan begins to pay 100% of the Maximum Allowed Amount for Covered Services. The Annual Out-of-Pocket Limit does not include amounts over the Maximum Allowed Amount, or charges for services that your Plan does not cover. The Annual Out-of-Pocket Limit may consist of Deductibles, Coinsurance and/or Copayments.

Authorized Services

See "precertified services."

Coinsurance

The percent applied to covered charges (not including Deductibles) for certain Covered Services or supplies in order to calculate benefits under the Plan. These are shown in the Summary of Medical Benefits. The term does not include Copayments. For example, if the Plan's Coinsurance for an item of expense is 90%, then the covered person's Coinsurance for that item is 10%.

Copayment

The fee or amount you pay for office visits and certain Covered Services when you use In-Network Providers. The Plan then pays 100% of remaining covered expenses.

Covered Employment

Work covered by a collective bargaining agreement between your employer and the Union. The collective bargaining agreement requires your employer to contribute to the Plan on your behalf.

Covered Services

The services for which the Plan provides benefits in accordance with this document.

Deductible

The dollar amount you must pay each calendar year before the Plan pays benefits for Covered Services. If you have family coverage, once the first family member meets the individual Deductible, the plan will pay benefits for that family member. However, the benefits for other family members will not be paid until 2 or more eligible family members meet the family Deductible. Once the family Deductible is met, the Plan will pay benefits for Covered Services for the remainder of the year for all eligible family members. The exception to this rule is a common accident benefit—if 2 or more family members are injured in the same accident and require medical care, the family must meet only one individual Deductible.

Hospital/Facility

For purposes of certifying inpatient services, a Hospital or Facility must be a fully licensed acute-care general Facility that has all of the following on its own premises:

- A broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies;
- 24-hour general nursing service with registered nurses who are on duty and present in the Hospital at all times;
- A fully staffed operating room suitable for major surgery, together with anesthesia service and equipment. The Hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care;
- Assigned emergency personnel and a "crash cart" to treat cardiac arrest and other medical emergencies;
- Diagnostic radiology facilities;
- A pathology laboratory; and
- An organized medical staff of licensed doctors.

For pregnancy and childbirth services, the definition of "Hospital" includes any birthing center that has a participation agreement with either Empire or another BlueCross BlueShield plan.

For physical therapy purposes, the definition of a "Hospital" may include a rehabilitation Facility either approved by Empire or participating with Empire or another BlueCross BlueShield plan other than specified above.

For kidney dialysis treatment, a Facility in New York State qualifies for In-Network Benefits if the Facility has an operating certificate issued by the New York State Department of Health, and participates with Empire or another BlueCross BlueShield plan. In other states, the Facility must participate with another BlueCross BlueShield plan and be certified by the state using criteria similar to New York's. Out-of-network benefits will be paid only for Non-Participating Facilities that have an appropriate operating certificate.

For behavioral healthcare purposes, the definition of "Hospital" may include a Facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a Facility operated by the Office of Mental Health; or a Facility that has a participation agreement with Empire to provide mental and behavioral healthcare services. For alcohol and/or substance abuse received out-of-network, a Facility in New York State must be certified by the Office of Alcoholism and Substance Abuse Services. A Facility outside of New York State must be approved by the Joint Commission on the Accreditation of Healthcare Organizations.

For certain specified benefits, the definition of a "Hospital" or "Facility" may include a Hospital, Hospital department or Facility that has a special agreement with Empire.

Empire's EPO does not recognize the following facilities as Hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted above); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges, or camps.

In-Network Benefits

Benefits for Covered Services delivered by In-Network Providers and Suppliers. Services provided must fall within the scope of their individual professional licenses.

In-Network Provider/Supplier

A doctor, other professional Provider, or a durable medical equipment, home health care or home infusion supplier who:

- Is in Empire's PPO network;
- Is in the PPO network of another BlueCross BlueShield plan; and/or
- Has a negotiated rate arrangement with another BlueCross BlueShield plan that does not have a PPO network.

Itemized Bill

A bill from a Provider, Hospital or ambulance service that gives information that the Plan needs to settle your claim. Provider and Hospital bills will contain the patient's name, diagnosis, and date and charge for each service performed. A Provider bill will also have the Provider's name and address and descriptions of each service, while a Hospital bill will have the subscriber's name and address, the patient's date of birth and the plan holder's Plan identification number. Ambulance bills will include the patient's full name and address, date and reason for service, total mileage traveled and charges.

Medically Necessary

Services, supplies or equipment provided by a Hospital or other Provider of health services that are:

- Consistent with the symptoms or diagnosis and treatment of the patient's condition, illness or injury;
- In accordance with standards of good medical practice;
- Not solely for the convenience of the patient, the family or the Provider;
- Not primarily custodial; and
- The most appropriate level of service that can be safely provided to the patient.

The fact that a network Provider may have prescribed, recommended or approved a service, supply or equipment, does not make it Medically Necessary.

Non-Participating Hospital/Facility

A Hospital or Facility that does not have a participation agreement with Empire or another BlueCross BlueShield plan to provide services to persons covered under Empire's EPO contract. Or, a Hospital or Facility that does not accept negotiated rate arrangements as payment in full in a plan area without a PPO network.

Operating Area

Empire operates in the following 28 eastern New York State counties: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.

Out-of-Network Providers/Suppliers

A doctor, other professional Provider, or durable medical equipment, home health care or home infusion supplier who:

- Is not in Empire's PPO network;
- Is not in the PPO network of another BlueCross BlueShield plan; and/or
- Does not have a negotiated rate with another BlueCross BlueShield plan.

Under this Plan, out-of-network benefits are paid by the Fund Office.

Outpatient Surgery

See "same-day surgery."

Participating Hospital/Facility

A Hospital or Facility that:

- Is in Empire's network;
- Is in the PPO network of another BlueCross BlueShield plan; and/or
- Has a negotiated rate arrangement with another BlueCross BlueShield plan that does not have a PPO network.

Plan Administrator

The person who has certain authority concerning the health plans, such as plan management, including deciding questions of eligibility for participation, and/or the administration of plan assets. Empire is not the Plan Administrator. To identify your Plan Administrator, contact your employer or health plan sponsor.

Precertified Services

Services that must be coordinated and approved by Empire's Medical Management or Behavioral Healthcare Management Programs to be fully covered by the Plan. Failure to precertify may result in a reduction or denial of benefits.

Provider

A Hospital or Facility, or other appropriately licensed or certified professional health care practitioner.

For behavioral health care purposes, "Provider" includes care from psychiatrists, psychologists or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders.

Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have 3 years of post-degree supervised experience in psychotherapy and an additional 3 years of post-licensure supervised experience in psychotherapy.

For maternity care purposes, "Provider" includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed Facility and whose services are provided under qualified medical direction.

To the extent required by the Patient Protection and Affordable Care Act of 2010, if a service is covered under the Plan, the Plan will not discriminate based on the license or certification of the individual providing the service if:

- The individual is licensed to provide such services in the state in which the services are performed; and
- The individual is acting within the scope of that license.

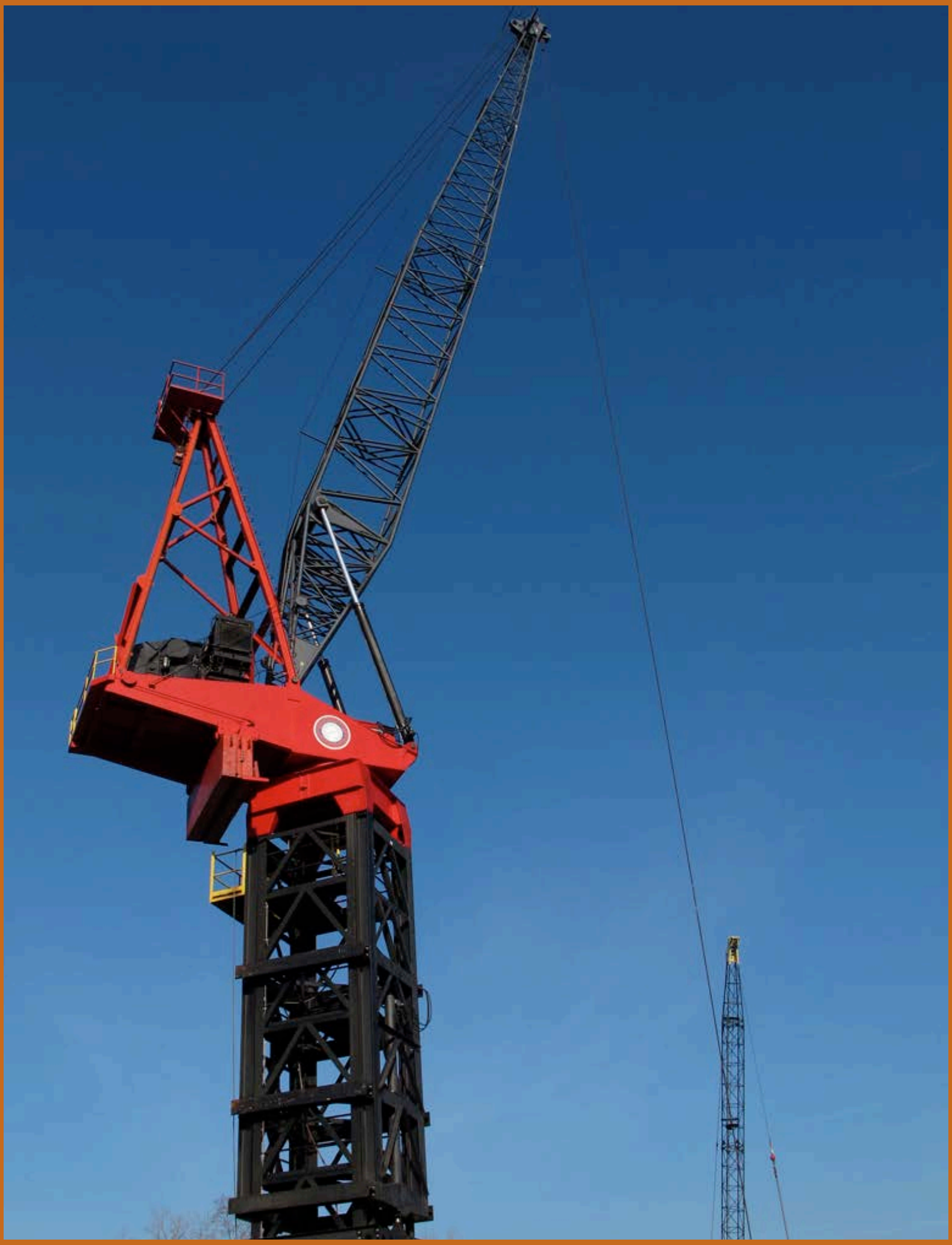
Same-Day Surgery

Same-day, ambulatory or outpatient surgery is surgery that does not require an overnight stay in a Hospital.

Treatment Maximums

Maximum number of treatments or visits for certain conditions.

Notes



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