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NOTICE: THE FUND’S HEALTH PLAN IS CONSIDERED “GRANDFATHERED” UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Board of Trustees of the International Union of Operating Engineers Health and Welfare Fund (the “Fund”) believes this Fund is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act, or ACA). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your health plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Funds Office at 1-888-486-3524 or via the Plan’s website at www.local4funds.org.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.
SECTION I: Eligibility Rules and Coverage Options

Health and Welfare Plan

As a participant in the International Union of Operating Engineers, Local 4 Health and Welfare Plan, you are covered by a comprehensive benefits program. The Plan is designed to protect and provide for you and your family through a broad range of unexpected events and extraordinary expenses. This document is intended to satisfy the requirements for a Plan Document and Summary Plan Description (SPD) as specified in the Employee Retirement Income Security Act (ERISA). You can determine your rights under this Plan by consulting this SPD. The Fund has made every effort to make this Plan Document and SPD as accurate as possible. This Plan Document and SPD was published in January 2015 and is effective for benefits on and after January 1, 2015. It replaces all Healthlines, SPDs and Plan Documents previously published or made available. The Board of Trustees expects to continue this benefit Plan indefinitely, but reserves the right to change or terminate the Plan at any time. If the Plan is terminated, benefits will be settled according to provisions of the Plan and applicable trust agreement.

Eligibility

(Eligibility rules for hours worked beginning January 1, 2014)
As a covered employee, you earn eligibility for health and welfare benefits once you accumulate sufficient work hours during a calendar year as described in Basic Eligibility Rule. You are then covered under the comprehensive Basic Benefits Plan for the 12-month period beginning the following March 1 through February 28 (or February 29 during a leap year).

Your eligibility for health and welfare benefits is determined as contributing employers submit remittance reports to the Funds Office. Based on these reports, the Funds Office reviews the number of hours you worked to determine whether you are eligible for coverage during the current benefit period under the Basic or the Supplemental Eligibility Rule. Hours you worked during an eligibility period may not be carried over to any other eligibility period.

Each participating employer remits a monthly report, which is due the 19th of the month following the month in which the work was performed. The hours reported on the 19th of the month relate to the hours you worked the preceding month. Initial eligibility (“initial” can be either the first time you become insured or become insured again after a lapse in coverage) is earned under the Supplemental Eligibility Rule. Subsequent, consecutive eligibility is earned under the Basic Eligibility Rule.
Basic Eligibility Rule

As a covered employee, you must work 1,000 or more credited hours (1,500 or more hours if you are a participant in Local 4D covered by an Equipment House Contract or 1,800 or more hours for a non-collectively bargained employee covered under a Participation Agreement) during a calendar year (January through December) to become eligible for comprehensive health and welfare benefits under the Basic Eligibility Rule. You are then covered under the comprehensive Basic Benefits Plan for the 12-month period beginning the following March 1 through February 28 (or February 29 during a leap year).

All Office Employees of the Office employers are eligible to participate in the Local 4 Health and Welfare Fund. An Office Employee participates in the Plan if his or her Office employer signs a Participation Agreement with the Fund covering that Office Employee’s classification. An Office Employee covered by the Participation Agreement will be eligible for benefits from the Health and Welfare Fund on the first day of the month following employment with the Office employer provided that contributions are made on the Office Employee’s behalf. Continued eligibility after termination of employment will be based on the Health and Welfare Fund’s eligibility rules and in accordance with the applicable provisions of the Plan Document.

If you cannot meet the requirements of the Basic Eligibility Rule, you may become eligible for health and welfare benefits under the alternative requirements of the Supplemental Eligibility Rule.

Supplemental Eligibility Rule

As a covered employee, including in Local 4D covered by an Equipment House Contract, or as a non-collectively bargained employee covered under a Participation Agreement, you will become eligible for coverage under the Supplemental Benefits Plan on the first day of the month following the month you work 500 or more credited hours during the calendar year.

If you are enrolled under the Supplemental Benefits Plan, you are not eligible for weekly accident and sickness benefits or eligible to earn disability credit unless you purchase these benefits through the Bridge Plan. See Disability Credit for disability credit by virtue of collecting Unemployment Compensation.

If you become eligible under the Supplemental Eligibility Rule, you will be covered under the Supplemental Benefits Plan through the following February 28. See Supplemental Benefits Plan Coverage later in this section for an overview of the differences between Basic Benefits and Supplemental Benefits.

Eligibility Rule Example:

If you are a member of Local 4 or Local 4D, or you are a non-collectively bargained employee (covered under a Participation Agreement), and you work 500 or more credited hours beginning January 1, 2014, you will become eligible under the Supplemental Eligibility Rule, as described above, on the first day of the month following the month in which you reached 500 credited hours.

Let’s assume you work 160.0 hours each month in March, April, May and June 2014. Your Supplemental coverage would begin on July 1, 2014, and would terminate on February 28, 2015.

If you meet the hours requirement applicable to you below in 2014, you would become eligible under the Basic Eligibility Rule for coverage under the Basic Benefits Plan starting on March 1, 2015, and continuing through February 29, 2016.

- Local 4 participant – 1,000
- Local 4D participant – 1,500
- Non-collectively bargained employee – 1,800
Supplemental Benefits Plan Coverage
(for those covered under the Supplemental Eligibility Rule)

Covered employees who earn their coverage based on the Supplemental Eligibility Rule are covered under the Medical Plan, but benefits are reduced or absent in the following areas:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage</th>
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<tbody>
<tr>
<td>Medical Plan</td>
<td>Same coverage as Basic Benefits Plan</td>
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<td>Prescription Drug Program</td>
<td>Coverage reduced (see Prescription Drug Program)</td>
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<td>Dental Plan</td>
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<tr>
<td>Hearing Plan</td>
<td>No coverage</td>
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<tr>
<td>Vision Plan</td>
<td>No coverage</td>
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<tr>
<td>Life Insurance Plan</td>
<td>No coverage</td>
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<tr>
<td>Accidental Death &amp; Dismemberment Plan</td>
<td>No coverage</td>
</tr>
<tr>
<td>Weekly Accident and Sickness (Loss of Time) Plan</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

Disability Credit

If you cease to be eligible for Health and Welfare Plan coverage because you were disabled, and as a result were unable to accumulate work hours during the calendar year, you may be credited with six hours per day (up to 30 hours per week) for each week you collected Weekly Accident and Sickness benefits under the Plan, for up to 26 weeks. To be entitled to receive disability credit, you must:

- Remain disabled and submit satisfactory proof to the Plan of your disability;
- Be eligible for the Basic Benefits Plan on the date disability commences, or be eligible on that date by virtue of having purchased benefits through the Bridge Buy-In Plan;
- Have been continuously eligible for benefits for at least 12 months prior to the onset of the disability; and
- Apply for the credit within 24 months of losing earned coverage.

You may not earn more than 52 weeks of disability credit in any consecutive five-year period.

If you are disabled and receiving Workers’ Compensation benefits, you will also receive disability credit, subject to the same limitations outlined in this section, if you are eligible under the Basic Benefits Plan or the Bridge Buy-In Plan. If disability credit is granted, you must use the full amount based on the dates certified. Partial credit will not be granted. You must submit satisfactory proof to the Plan that you are receiving a weekly Workers’ Compensation benefit.

You may also be eligible for disability credit subject to the same limitations as above for time when you are disabled from Covered Employment but otherwise eligible for and receiving Unemployment Compensation and eligible for Loss of Time benefits. Documentation of your disability and your eligibility for Unemployment Compensation is required. This benefit first became effective for Unemployment Compensation earned in 2010. If credit is granted, you will receive credit for all benefits. However, you cannot file a Loss of Time claim if you are collecting Unemployment Compensation.

Bridge Plan

Participants insured through the Supplemental Eligibility Rule are eligible to purchase all of the Basic Benefits Plan benefits through the Bridge Buy-In Plan if purchased when they are first eligible for benefits under the Supplemental Eligibility Rule. Contact the Funds Office for premium information. Benefits under this Plan include the same benefits as under the Basic Benefits Plan: Medical, Prescription, Dental, Hearing, Vision, Life Insurance, Accidental Death and Dismemberment, and Weekly Accident and Sickness (Loss of Time) benefits.
Benefits Buy-In Plan A

If you do not have enough hours for health plan coverage, you may be able to buy in to the Plan through a special arrangement referred to as Plan A. The buy-in premium amount depends on the number of hours you worked in the previous year for which Health and Welfare contributions were paid to the Plan. Plan A credits you with the hours you have earned to reduce your premium cost for the Plan.

The Plan A premium is based on the following formula: 1,500 hours for Local 4 or 1,800 hours for Local 4D, less the total of your earned hours, multiplied by the current standard hourly contribution rate.

**Formula example for Local 4 member:**

\[
\begin{align*}
1,500 & \quad \text{Hours (Cost of the Plan)} \\
- 470 & \quad \text{Worked Hours} \\
\hline
= 1,030 & \quad \text{Balance of Hours} \\
\text{\hphantom{= 1,030}} & \quad \text{\hphantom{Balance of Hours}} \\
1,030 & \quad \text{Balance of Hours} \\
\times $10.00 & \quad \text{Example Contribution Rate} \\
\hline
= $10,300 & \quad \text{Total Yearly Cost You Will Pay ($2,575.00 is due each quarter)}
\end{align*}
\]

Benefits can be purchased on this basis for a maximum of two consecutive years if you are not working but are looking for work as certified by your Business Agent (a Buy-In Affidavit must be completed) or until you are eligible for Supplemental Plan benefits.

If you elect to continue coverage under Benefits Buy-In or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and later become eligible due to earned hours, any premium paid from the date you become eligible will be reimbursed.

Once your eligibility under Plan A has terminated, you must exercise COBRA rights in order to maintain coverage. See Continuing Your Coverage (COBRA).

You earn Health and Welfare benefit eligibility by meeting the requirements of either the Basic Eligibility Rule or the Supplemental Eligibility Rule. If your eligibility ends due to a lack of or a reduction in work hours, you may be able to continue your coverage by buying in to the Plan. Contact the Funds Office for details, or consult Benefits Buy-in Plan A, to the left.

Making Changes to Your Coverage

Changes to your coverage once you are already enrolled are effective as of the date your change in status occurs, provided the required Proof Documents are received within 60 days of the event. For example, if you marry or have a child, your coverage extends to your new spouse or dependent as of the date of marriage, birth or adoption, provided the Funds Office receives the required documents within 60 days of the marriage, birth or adoption. Otherwise, the effective date of coverage will be on the first day of the month following the month in which the Proof Documents are received by the Funds Office.

To add a dependent, the Funds Office requires a certified copy of your marriage certificate or your child's long-form birth certificate from the city or town hall, or the court documents related to the adoption. See Proof Documents to Add Eligible Dependents to the Health Plan for more information. You will also need to complete an enrollment (census) form and return it to the Funds Office. You may obtain an enrollment form by calling the Funds Office or by downloading a form from the Fund's website at www.local4funds.org.

The Fund also requires the Social Security number of each person covered by the Plan.
Special Enrollment Rights

Group health plans must allow individuals (who are otherwise eligible) to enroll upon certain specified events regardless of any late enrollment provisions if enrollment is requested within 60 days of the event. The Plan provides for Special Enrollment as follows:

Newly Acquired Spouse and/or Dependent Child(ren)
If you are enrolled for individual coverage and you acquire a Spouse by marriage, or if you acquire any dependent Children by birth, adoption or placement for adoption, you may enroll your newly acquired Spouse and/or any Dependent Child(ren) no later than 60 days after the date of marriage, birth, adoption or placement for adoption. Contact the Funds Office for information on how to enroll a new Spouse or Child.
• If you are not enrolled for individual coverage and you acquire a Spouse by marriage, or if you acquire any dependent Children by birth, adoption or placement for adoption, you may enroll yourself and your newly acquired Spouse and/or any dependent Child(ren) no later than 60 days after the date of marriage, birth, adoption or placement for adoption.
• If you did not enroll your Spouse for coverage within 60 days of the date on which he or she became eligible for coverage, and you subsequently acquire a dependent Child by birth, adoption or placement for adoption, you may enroll your Spouse together with your newly acquired dependent Child no later than 60 days after the date of your newly acquired dependent Child’s birth or placement for adoption.

Loss of Other Coverage
If:
• You did not enroll yourself, your Spouse and/or any dependent Child(ren) for coverage within 60 days after the date on which you or they first became eligible for coverage because you or they had health care coverage under any other health insurance policy or program or employer plan, including COBRA Continuation Coverage, individual insurance, Medicare, Medicaid or other public program; and
• You, your Spouse and/or any dependent Child(ren) cease to be covered by that other health insurance policy or plan;

you may enroll yourself and/or that Spouse and/or Dependent Child(ren) within 60 days after the termination of their coverage under that other health insurance policy or plan if that other coverage terminated because:
• Of the loss of eligibility for that other coverage as a result of termination of employment or reduction in the number of hours of employment, or as a result of death, divorce or legal separation; or
• Of the termination of employer contributions toward that other coverage; or
• A covered individual reaches the lifetime limit for all benefits under the other health plan; or
• If that other coverage was COBRA Continuation Coverage, the coverage was “exhausted.” COBRA Continuation Coverage is “exhausted” if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim). For example, COBRA coverage is considered “exhausted” when the 18- or 36-month maximum coverage period expires or when the individual no longer resides, lives or works in a service area of the Plan (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual.

Also, an individual may be eligible for Special Enrollment even if he or she did not have other health coverage when he or she initially refused to enroll in the Fund. This may occur if, after subsequently obtaining other health coverage, he or she later loses that other health coverage.

Finally, if you or your dependent lose eligibility for Medicaid or the Children’s Health Insurance Program (CHIP), or become eligible to participate in a premium assistance program under Medicaid or CHIP, you may enroll yourself or your eligible dependent in the Fund’s health coverage if you request enrollment within 60 days of the loss of Medicaid or CHIP coverage, or the date you or your dependent are determined to be eligible for a Medicaid or CHIP premium assistance program.

Participants are always eligible for enrollment upon earning the requisite number of hours.

If you have any questions about your Special Enrollment Rights, contact the Funds Office.
If You Are a Pensioner

**Earned Coverage**

Regardless of your age and your spouse’s age when you retire, you, your spouse and any eligible covered dependents remain covered under the Plan until your Earned Coverage expires.

After you retire, you, your eligible covered spouse and your eligible covered dependents may remain covered under the Medical, Prescription Drug, Dental and Vision Plans, provided you were covered under the Health and Welfare Plan for at least five out of the seven benefit periods preceding your retirement date. Only the spouse to whom you are married when you retire is eligible for health coverage upon your retirement.

Your Weekly Accident and Sickness, Life Insurance, and Accidental Death and Dismemberment (AD&D) benefits terminate when your Earned Coverage ends. You may be eligible to convert your Life and AD&D insurance to individual policies at this time. See Life Insurance Plan and AD&D Insurance Plan for details.

**Extended Coverage**

**Eligibility**

After your Earned Coverage expires, you may purchase Extended Coverage. You are eligible to purchase Extended Coverage if:

- You are eligible for benefits on the effective date of your retirement under the International Union of Operating Engineers, Local 4 Pension Plan; or
- You retire on a disability pension; or
- Your pension effective date falls on or after the date you reach age 62 and you have been eligible for coverage under this Plan for five of the most recent seven benefit periods (March 1 through February 28).

**Coverage Options and Duration**

Your Extended Coverage benefits and duration vary depending on your age and your spouse’s age when you retire. If you meet the Extended Coverage eligibility rules outlined above, there are two coverage options:

**Regular Retirement and Disability Option:** You may buy in to this Extended Coverage option if:

- You and your spouse are at least age 62 when you retire; or
- You are disabled and under age 62 when you retire.

Coverage continues for up to two years, or until you become eligible for Medicare, whichever occurs first.

**Early Retirement Option:** You may buy in to this Extended Coverage option if:

- Both you and your spouse are under age 62 when you retire; or
- For your spouse, if your spouse is under age 62 when you retire.

Coverage continues for up to 10 years, or until you become eligible for Medicare, whichever occurs first.

You and your spouse may qualify for different coverage options depending on your age, your disability status and your spouse’s age. Coverage for your spouse and/or eligible dependents may continue under Extended Coverage if they are otherwise eligible and you pay the appropriate premium.

If your spouse is under age 65 and Medicare eligible due to a disability when you retire, he or she may be eligible for up to 18 months of coverage through COBRA. See Continuing Your Coverage (COBRA) for more information.

**Benefits**

Your Extended Coverage benefits vary depending on your coverage option:

- **Regular Retirement and Disability Option** – Medical, Prescription Drug, Dental and Vision coverage.
- **Early Retirement Option** – Medical and Prescription Drug coverage.
Coverage Cost

Your share of the Extended Coverage cost is based on the coverage option you qualify for when you retire. The longer you work under the Plan, the lower your self-payment contribution will be for pensioner medical coverage.

- **Regular Retirement and Disability Option** – The premium is based on 50% of the cost of coverage, calculated as a minimum of 1,800 hours times the negotiated IUOE Local 4 Master Agreement hourly rate of contribution.
- **Early Retirement Option** – The premium is based on 100% of the COBRA rates, which are determined each year based on the Plan’s past claims experience.

These costs are subject to change from time to time. For details, contact the Funds Office.

### IUOE Local 4 Extended Coverage

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<th>Eligibility</th>
<th>Duration</th>
<th>Benefits</th>
<th>Coverage Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Retirement and Disability Option</td>
<td>Retired Member and Spouse age 62 to 65&lt;br&gt;Retired Member age 62 to 65&lt;br&gt;Disabled Retired Member under age 62&lt;br&gt;Eligible Dependent Children up to age 26</td>
<td>Up to 2 years or until Medicare eligible, if earlier</td>
<td>Medical, Prescription Drug, Dental and Vision</td>
<td>50% x (1,800 hours x Local 4 Master Agreement hourly contribution rate) / 12*</td>
</tr>
<tr>
<td>Early Retirement Option</td>
<td>Retired Member and Spouse under age 62&lt;br&gt;Spouse under age 62&lt;br&gt;Eligible Dependent Children up to age 26</td>
<td>Up to 10 years or until Medicare eligible, if earlier</td>
<td>Medical and Prescription Drug</td>
<td>100% of COBRA rate (Individual or Family Rate)</td>
</tr>
</tbody>
</table>

*Formula produces the Two-Person Rate. Individual Rate is half this amount; Family Rate is three times the Individual Rate.*

Non-Covered Employment

You immediately cease being a covered employee under this Plan if you become employed by an employer who is not required to make contributions to the Plan in a category of employment that otherwise would be considered covered employment. In this case, your coverage and your covered dependents’ coverage end as of the date the Funds Office receives notification that you are no longer working in covered employment.

If you are an apprentice who is terminated by the Hoisting and Portable Engineers Local 4 Apprenticeship and Training Program, you are no longer a covered employee as of the date of termination.

If your coverage or your dependents’ coverage ends for the reason cited here, you may continue coverage through COBRA. See [Continuing Your Coverage (COBRA)](#).

Reciprocity

To ensure continuous credit under the Health and Welfare Fund, the Plan has reciprocal agreements with many other locals of the International Union of Operating Engineers and an agreement through a National Health & Welfare Reciprocity Agreement. These agreements provide for transfer to this Fund of any contributions made on your behalf to another Fund.

To receive credit for contributions made on your behalf to other Funds, you must notify the Plan Administrator of the:

- Name of the employer;
- Local union in whose jurisdiction you are working; and
- Date your employment began and ended.

A special form can be completed within six months following the date on which you commenced work in the area of another local union. This form can be obtained from the Funds Office.
Covering Your Dependents

Once you meet the Plan’s eligibility requirements, your eligible dependents are also covered under the Plan.

Eligible Dependents include:
- Your lawful spouse, provided he or she is not legally divorced from you.
- Your married or unmarried child up to age 26, regardless of whether or not the child is eligible for his or her own employment-based health coverage.
- A mentally or physically handicapped unmarried child incapable of self-support age 26 or older, provided his or her handicap commenced prior to attaining age 26, for whom you are at least 50% responsible for support and maintenance.
- For Plan purposes, the term “child” or “children” includes your natural children, legally adopted children, children placed with you for adoption, stepchildren through a current marriage,* foster children, children for whom you have legal guardianship or other children who meet the Plan’s eligibility requirements.

*If your stepchild is covered by the Plan and then you divorce the biological parent of the stepchild, and you are not the legal guardian or adoptive parent of the stepchild, the stepchild is no longer eligible for coverage.

In order to determine whether your dependents qualify under the Plan, you are required to provide a birth certificate or proof of marriage, parentage, adoption or guardianship status; the dependent’s Social Security number (required by law) or status of total disability; or any other documentation that the Funds Office may deem necessary. See Proof Documents Required to Add Eligible Dependents to the Health Plan, below.

The Plan also covers your dependent children if they are required to be covered under a Qualified Medical Child Support Order (QMCSO), unless state or federal rules determine otherwise. See Qualified Medical Child Support Orders (QMCSOs).

For information on when coverage ends, or to continue coverage for a former spouse or for a dependent child beyond the Plan’s age limits, see Continuing Your Coverage (COBRA).

Proof Documents Required to Add Eligible Dependents to the Health Plan

It is the policy of the IUOE Local 4 Health and Welfare Fund to require Proof Documents validating the relationship between our Participant and his or her dependents for whom he or she seeks coverage under the Health Plan.

The following is a list of the Proof Documents required by the Plan.

- **Lawful Spouse:** To add your lawful Spouse to your Health Plan coverage the Fund must receive a city/town hall-certified copy of your marriage certificate. The document will be verified, a copy will be retained at the Funds Office and the original will be mailed back to the Participant.
- **Ex-Spouse:** To add your ex-Spouse to the Health Plan the Fund must receive the divorce decree, including the settlement agreement and the judgment NISI. The divorce decree must specify that you are required to provide health plan coverage to your ex-Spouse.
- **Biological Child of the Participant and/or the Biological Child of the Participant’s Legal Spouse:** To add a biological child to the Health Plan, the Fund must receive a city/town hall-certified copy of the long-form birth certificate. The document will be verified, a copy will be retained at the Funds Office and the original will be mailed back to the Participant. The short/abstract certificate is not acceptable.
Social Security Number Requirement
Participants must submit their Social Security number as well as the Social Security numbers of all dependents who will be covered under the Plan.

Why are the Social Security numbers of all Plan Participants required?
Each quarter, an electronic file containing the demographic information (including the Social Security number) of all Plan Participants is submitted to the Centers for Medicare and Medicaid Services (CMS), as required by law.

Children Who Are Disabled
Your covered child who is physically or mentally incapable of self-support as of age 26 may continue to be covered under the Plan while remaining disabled and unmarried, as long as your own coverage remains in effect. To continue coverage of a child under this provision, the Funds Office must receive proof of the child's disability or handicap within 31 days after coverage would otherwise terminate. Any continued coverage is available only to the extent permitted under provisions of the Plan.

You may be required to provide satisfactory proof of continuance of your child’s mental or physical disability and have your child examined or to permit an examination at any time or times after receiving proof of your child’s ongoing disability. When your child ceases to be so disabled, coverage with respect to that child shall cease at the end of the month in which he or she is no longer disabled.

Legally Adopted (or Legal Guardianship) Child: To add to the Health Plan a legally adopted child or child for whom the Participant was given legal guardianship, you are required to provide the court documents relative to the adoption/guardianship of the child, as well as certified copy of the long-form birth certificate from the city/town hall. The document will be verified, a copy will be retained at the Funds Office and the original will be mailed back to the Participant. The Short/Abstract Certificate is not acceptable.

Disabled Child: If your child is totally disabled, you are also required to provide an Attending Physician’s Statement (to be completed by your child’s physician). Please contact the Funds Office at 1-888-486-3524 to obtain the form.

The Plan will not add a dependent spouse/ex-spouse/child to the Health Plan without the submission of the required documentation by the Participant, which is considered part of a completed request for enrollment. For new Participants the information must be received by the Funds Office within 60 days of the activation of the Health Plan coverage in order for the dependent spouse/ex-spouse/child to have the same Health Plan effective date as the new Participant; otherwise, the effective date of the dependent spouse/ex-spouse/child will be on the first day of the month following the month in which the documents are received by the Funds Office.

If you are already covered by the Health Plan and you get married, have a baby or adopt a child, the information must be received by the Funds Office within 60 days of the event; otherwise the Health Plan effective date of the dependent will be on the first day of the month following the month in which the documents are received by the Funds Office. If the new Dependent Child is gained by birth, adoption or placement for adoption, enrollment will be retroactive to the date of birth or the date of adoption or placement for adoption, provided the completed request for enrollment with all Proof Documents is received within the 60-day time limit.
When Your Coverage Ends

Your coverage under the Health and Welfare Plan terminates at the earliest of the dates shown in the following chart:

<table>
<thead>
<tr>
<th>For you as an active covered employee, coverage ends at the earliest date:</th>
<th>For your covered dependents, coverage ends at the earliest date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• You no longer meet the Plan’s eligibility requirements;</td>
<td>• Your coverage ends;</td>
</tr>
<tr>
<td>• You enter Non-Covered Employment, or you are an apprentice who has been terminated from the Hoisting and Portable Engineers Local 4 Apprenticeship and Training program;</td>
<td>• You are divorced, unless a court decree specifies otherwise (this change affects your spouse’s coverage only);</td>
</tr>
<tr>
<td>• The Plan terminates;</td>
<td>• Your Dependent Child no longer meets the definition of a Dependent under the Plan. In this case, coverage terminates at the end of the month in which the child reaches age 26;</td>
</tr>
<tr>
<td>• You enter active duty with the uniformed services. If the period of active duty exceeds 30 days you have two options. You may (1) run out your earned coverage and elect COBRA coverage for up to 24 months, or (2) freeze your earned coverage and enroll in a government-sponsored plan;</td>
<td>• The Plan terminates;</td>
</tr>
<tr>
<td>• If you are available for work and notify your employer or IUOE Local 4 within 14 days from the date of your release from the uniformed services (or within 90 days from such date, if your uniformed service lasted more than 180 days), your coverage will be reinstated. (You should also notify the Funds Office, even though not required to do so, to help address benefits issues on your return in a timely manner.) If you do not notify your employer or IUOE Local 4 that you are available for work within 14 or 90 days of your date of release from the uniformed services, as applicable, you must once again meet the Plan’s eligibility requirements before becoming eligible for coverage.</td>
<td>• Your Dependent Child begins active duty with the uniformed services. If the period of active duty exceeds 30 days, the Plan will offer COBRA coverage to the Dependent Child, as outlined in this chart to the left.</td>
</tr>
</tbody>
</table>

Coverage for an Office Employee of an Office employer who became initially eligible for coverage in the Health and Welfare Plan under the terms of a Participation Agreement will terminate at the end of the eligibility period as defined in the Plan.
If You Enter Active Military Duty

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you and your dependents have the right to continue your group health care coverage for up to 24 months if you are on a leave of absence for active duty in the uniformed services of the United States. This coverage is similar to COBRA coverage, except that COBRA coverage for those not in the military service generally continues for up to 18 months. If your leave is for less than 31 days, your premium payment will be the contribution or premium (if any) that you would normally pay while working under the Plan, rather than the full COBRA premium. For more information about filing for coverage under USERRA, contact the Funds Office.

If you report back within 90 days of your discharge date if your period of military service was more than 180 days, or within 14 days from the date of discharge if the period was 31 days or more, but less than 181, your coverage will be reinstated. You may be charged for coverage at the COBRA rate if you ran out your earned coverage prior to entering the service. Contributing employers are permitted to make voluntary contributions on behalf of any Participant who is serving or who has served in qualified military service, regardless of whether the Participant worked for that employer.

If you wish to have coverage under USERRA, follow the procedures for the election of COBRA/Buy-In coverage.

If You Divorce

If, as the covered employee, you divorce while you are covered under the Plan and you have family coverage in effect on the date your divorce becomes final, your former spouse will be eligible for coverage only through a court decree that requires you to provide coverage for your former spouse. Coverage for your former spouse will remain in effect until the earliest of:

- The date either you or your former spouse remarries;
- The end of the period of time stipulated by the court decree; or
- The date your benefit eligibility under the Plan terminates.

If you or your former spouse remarries, your former spouse will be offered COBRA continuation coverage. You cannot cover more than one spouse or former spouse as a dependent under the Plan’s active coverage at any time, unless required by law. Where there is no court decree, coverage for your former spouse terminates at the end of the month in which the divorce is final. At this time, your former spouse is eligible to continue coverage under COBRA.

To establish coverage for your divorced spouse, a copy of the divorce decree is required showing the court order to provide coverage.

Pensioners and Their Eligible Spouses

If you are a pensioner or the eligible spouse of a pensioner and you are covered under extended coverage or earned coverage, your coverage under the Plan terminates:

- Once your earned coverage runs out; or
- If you are enrolled in extended coverage, at the earlier of the date you become eligible for Medicare or two years from the date your earned coverage ends.

Your dependent children who were also covered under your Plan who lost coverage due to your termination of employment (retirement) will be offered COBRA.
**Loss of Benefits**

You or your dependents may also experience a reduction or termination in benefits in any of the following circumstances:

- You fail to follow the Plan’s procedures, including the Plan’s Utilization Management procedures;
- You fail to pay required buy-in premiums, including the cost of extended coverage or COBRA continuation coverage;
- You fail to reimburse the Fund for a claim that was paid in error or otherwise paid but later retracted and denied;
- You suffer injuries for which a third party is responsible, and you or your attorney fail to sign the Plan’s subrogation agreement;
- You receive reimbursement for a covered expense from another plan which is primary to this Plan while also receiving primary reimbursement from this Plan;
- You receive a judgment or settlement or otherwise receive payment from any person or entity with respect to the illness, injury or other condition which gives rise to expenses this Plan pays and you fail to honor your subrogation agreement with the Fund;
- You are found to have committed a fraudulent act against the Plan including, but not limited to, the fraudulent filing of a claim for reimbursement; or
- The Plan is amended or terminated, but this applies only with respect to expenses incurred after the amendment or termination becomes effective.

**Upon Your Death**

If you die while you are a covered employee, your eligible dependents remain covered for the duration of your earned coverage. At that point, your eligible dependents may elect to continue coverage under COBRA for up to 36 months. See [Continuing Your Coverage (COBRA)](#).

Effective, January 1, 2014, if you die while you are a covered employee and before you retire, your surviving spouse may elect to purchase the extended coverage available to eligible pensioners (see [Extended Coverage](#) for details) if the surviving spouse has been eligible for coverage by this Plan for five of the most recent seven benefit periods. Such an election would be as an alternative to an election of COBRA coverage, and could continue for up to 10 years or until the spouse is Medicare eligible, if earlier, as long as all required payments are made.

**Paying the Cost of Benefits**

**If You Are an Active Participant**

Payments are made to the Fund on your behalf by your employer as a result of agreements negotiated between the International Union of Operating Engineers, Local 4 and various employers and employer associations.

These contributions, together with any deductibles, co-pays and coinsurance you may incur, are used to pay for your benefits. There is no other cost to you and your family for coverage under the Health and Welfare Plan as long as you remain an active covered employee and meet the Plan’s eligibility requirements. Participants who elect Plan A buy-in coverage or Bridge coverage will incur a premium cost for electing these plans.

**If You Are a Pensioner**

If you are a pensioner or the covered spouse of a pensioner, you pay your share of the cost of extended or COBRA coverage each month. When you become eligible for extended or COBRA coverage and choose to buy-in to the Plan, you receive coupon sheets for each year of your extended or COBRA coverage.

You should submit your monthly premium using the applicable coupon in your book. If you fail to pay for your coverage within the 30-day grace period, your coverage will be terminated as of the last day of the month for which you have submitted payment. To meet the requirements of the grace period your check must be postmarked no later than 30 days after the original due date.

**If You Are a COBRA Participant**

If your coverage is through COBRA, you pay your share of the cost of COBRA coverage each month. You receive a coupon sheet for each month of your COBRA coverage. You should submit your monthly premium using the appropriate coupon from your book. If you fail to pay for your coverage within the 30-day grace period, your coverage will terminate as of the last day of the month for which you have submitted payment.

To meet the requirements of the grace period your check must be postmarked no later than 30 days after the original due date.
If You Buy-In Under Plan A
If you do not have enough hours, you may be eligible to buy-in to the Plan through a special arrangement referred to as Plan A. Plan A credits you with hours you have earned to reduce your premium cost for the Plan. The Plan A premium is based on the following formula: 1,800 hours (for Local 4D) or 1,500 hours (for Local 4) less the total of your earned hours, times the current standard hourly contribution rate for the IUOE Local 4 Health and Welfare Plan.

This annual amount is then converted to a quarterly premium rate. Health benefits can be purchased on this basis for a maximum of two consecutive years if you are not working but looking for work as certified by your Business Agent or until you are eligible for Supplemental Benefits Plan coverage if working.

Continuing Your Coverage (COBRA)
This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The Plan’s COBRA Administrator is the International Union of Operating Engineers, Local 4 Health and Welfare Fund COBRA Administrator at 16 Trotter Drive, P.O. Box 660, Medway, MA 02053, 1-888-486-3524. The Plan’s COBRA Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage
COBRA continuation coverage is a temporary continuation of Medical, Prescription Drug, Vision, Hearing and/or Dental Plan coverage when such coverage would otherwise end because of a qualifying event. Actual coverage depends on which COBRA Plan you purchase. Specific qualifying events are listed later in this section. COBRA continuation coverage is offered to each person who is a qualified beneficiary.

Please note that you may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day Special Enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

A qualified beneficiary is someone who loses coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, participants, spouses of participants and dependent children of participants may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are a covered employee, you become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events occurs:
- Your hours of employment are so reduced that your eligibility terminates;
- Your employment or your participation as an apprentice in the Hoisting and Portable Engineers Local 4 Apprenticeship and Training Program ends for any reason other than your gross misconduct; or
- You enter Non-Covered Employment.

If you are the spouse of a covered employee, you become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occur:
- Your spouse dies;
- Your spouse’s hours of employment are so reduced that eligibility terminates;
- Your spouse’s employment or participation as an apprentice in the Hoisting and Portable Engineers Local 4 Apprenticeship and Training Program ends for any reason other than gross misconduct;
- Your spouse enters Non-Covered Employment;
- Your spouse becomes enrolled in Medicare (Part A, Part B or both); or
- You become divorced from your spouse and no court order is entered requiring continued coverage.

COBRA refers to you and your covered dependents as qualified beneficiaries. A qualified beneficiary is an individual who, on the day before a qualifying event occurs, is covered under the Health and Welfare Plan.
Dependent children become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occur:

- The parent-employee dies;
- The parent-employee’s hours of employment are so reduced that eligibility terminates;
- The parent-employee’s employment or participation as an apprentice in the Hoisting and Portable Engineers Local 4 Apprenticeship and Training Program ends for any reason other than gross misconduct;
- The parent-employee enters Non-Covered Employment;
- The parent-employee becomes enrolled in Medicare (Part A, Part B or both);
- The parent-employee becomes divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a dependent child.

The Plan offers COBRA continuation coverage to qualified beneficiaries only after the Plan’s COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B or both), the employer must notify the Plan’s COBRA Administrator of the qualifying event within 60 days. For the other qualifying events (divorce of the participant and spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to:

COBRA Administrator
International Union of Operating Engineers,
Local 4 Health and Welfare Fund
16 Trotter Drive
P.O. Box 660
Medway, MA 02053

Once the Plan’s COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either the date of the qualifying event or on the date that Plan coverage would otherwise have been lost.

The term “you” as it is used throughout this COBRA section refers to you or other qualified beneficiaries under COBRA.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the participant, enrollment of the participant in Medicare (Part A, Part B or both), divorce or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is related to entry into military service, COBRA continuation coverage lasts for 18 months; USERRA coverage lasts for 24 months.

When the qualifying event is the expiration of earned coverage, entering Non-Covered Employment or termination from the Hoisting and Portable Engineers Local 4 Apprenticeship and Training Program, COBRA continuation coverage lasts for up to 18 months.

There are two ways in which an 18-month period of COBRA continuation coverage can be extended, as described in the next section.

Disability Extension of 18-Month Period of Continuation Coverage

If the Social Security Administration determines that you or any of your covered family members is disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan COBRA Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

You must make sure that the Plan COBRA Administrator is notified in writing of the Social Security Administration’s determination within 60 days of the date of the determination and before the end of the 18-month period of
International Union of Operating Engineers – Local 4

COBRA continuation coverage. You must provide a copy of the Social Security determination to:

COBRA Administrator
International Union of Operating Engineers,
Local 4 Health and Welfare Fund
16 Trotter Drive
P.O. Box 660
Medway, MA 02053

You must also notify the Fund in writing within 30 days of the date the Social Security Administration determines that you are no longer disabled. Verbal notice is not binding until you confirm it in writing.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage
If your family experiences another qualifying event while receiving the initial 18 months of COBRA continuation coverage, the spouse and dependent children (only) in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former participant dies, enrolls in Medicare (Part A, Part B or both) or gets divorced, if the event that occurs would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event (e.g., reduction in work hours) not occurred. The extension also is available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:

COBRA Administrator
International Union of Operating Engineers,
Local 4 Health and Welfare Fund
16 Trotter Drive
P.O. Box 660
Medway, MA 02053

Verbal notice is not binding until you confirm it in writing.

If you become covered by Medicare while you are an active employee and you later experience a qualifying event (for example, you experience a reduction in your hours), your dependents may be eligible for continued coverage until the later of:

• 36 months from the date you first become covered by Medicare, or
• The maximum coverage period for the qualifying event (18 months in the case of a reduction in hours).

How to Continue Coverage Through COBRA
Both you and the Fund have responsibilities if qualifying events occur that make you or your covered dependents eligible for continued coverage.

You or your covered dependents must notify the Plan’s COBRA Administrator (as noted previously) in writing within 60 days of the date of the qualifying event, when one of the following events occurs:

• You become divorced;
• Your dependent child is no longer considered an eligible dependent as defined by the Plan; or
• You become entitled to Medicare.

To continue your coverage under COBRA, be sure to notify the COBRA Administrator in writing no later than 60 days after the date of your divorce, the date your covered dependent(s) is no longer eligible for coverage or the date you become entitled to Medicare. If you do not notify the Plan COBRA Administrator within 60 days of one of these events, you forfeit your COBRA rights.

Additionally, you must notify the Plan’s COBRA Administrator no later than 60 days after a qualified beneficiary entitled to receive COBRA coverage has been determined by the Social Security Administration (SSA) to be disabled and before the end of the 18-month COBRA period, and no later than 30 days after the SSA determines that a qualified beneficiary is no longer disabled.

When you notify the COBRA Administrator that one of these events has occurred, the COBRA Administrator will give you and/or your qualified beneficiary an election form to complete. The election form explains a qualified beneficiary’s right to continued coverage under COBRA.
**Election Period**

You and your covered dependents have 60 days in which to elect continued coverage, beginning on the later of the date:

- Your coverage terminates because of the qualifying event, or
- You or your covered dependents are notified of the right to elect continued coverage.

You have 45 days from the date you elect continuation coverage to pay your initial COBRA premium. If payment is not received within this time period, COBRA coverage will be canceled retroactively to the last day of the previous month.

If you or your eligible Dependent has provided notice to the COBRA Administrator of a divorce or legal separation, a beneficiary ceasing to be covered under the Plan as a dependent, or a second qualifying event, but are not entitled to COBRA, the COBRA Administrator will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within 14 days of receiving your notice.

**Type of Coverage**

While you are receiving continuation coverage, your benefits under COBRA remain the same as the applicable benefits offered to similarly situated active employees, including any changes that are made to the Plans.

Participants covered under the Supplemental Benefits Plan are eligible for COBRA coverage for those benefits, but are not eligible for continuation of Dental, Vision or Hearing benefits unless they previously purchased the Bridge Plan. No participants are eligible for Weekly Accident and Sickness benefits (Loss of Time), Life Insurance, or AD&D Insurance through COBRA.

**Cost of Continued Coverage**

In most cases, you and your covered dependents will be required to pay 102% of the full group cost for continued coverage. If you or a qualified beneficiary is eligible for extended COBRA coverage due to disability (as determined by the Social Security Administration), you or your qualified beneficiary must pay 150% of the full group cost for continued coverage from the 19th through the 29th month of coverage.

You must pay for coverage in monthly installments, and you must make your first payment no later than 45 days after the date you elect to continue coverage. Subsequent payments will be due on the first day of each month, with a 30-day grace period. Premium rates are effective each March 1 for the following 12-month period. If the cost of these benefits for active employees changes in the future, these cost changes may affect the cost of your continuation coverage. You will be notified in advance of any changes in the cost of coverage.

If a health care provider requests confirmation of coverage and (1) you or your eligible Dependents have elected COBRA but have not yet paid the premium (and the grace period is still in effect); or (2) you or your eligible Dependents are within the COBRA election period but have not yet elected COBRA, COBRA coverage will be confirmed to your health care provider but with notice that the premium has not been paid and that no claims will be paid until the amount due has been received by the Plan’s COBRA Administrator. Additionally, your provider will be informed that if the amount due is not received by the end of the grace period, your coverage will terminate retroactively.

**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](http://www.healthcare.gov).
Termination of Continued Coverage

Your right to purchase continued group coverage may end before the expiration of the maximum coverage period if:

- Any required premium is not paid on time;
- The Fund terminates any of the Plans for all employees;
- You or your covered dependent(s) becomes entitled to Medicare (except that if a covered employee becomes entitled to Medicare, his or her covered family members may continue coverage for up to 36 months from the date of the initial qualifying event); or
- You or your covered dependent(s) become covered under another group health plan (as an employee or otherwise). If you or a covered dependent has a pre-existing condition that is not covered under the other plan due to a pre-existing condition limitation clause, you may continue coverage under this Plan until the end of the maximum continuation period, except if such clause does not apply to you (or if you satisfy it) or a covered dependent because of the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the ACA; or
- The employer that you worked for before the qualifying event has stopped contributing to the plan, and the employer establishes one or more group health plans covering a significant number of the employer’s employees formerly covered under the plan, or the employer starts contributing to another multi-employer plan that is a group health plan.

If continuation coverage is terminated before the end of the maximum coverage period, the COBRA Administrator will send a written notice as soon as practicable following the determination that continuation coverage will terminate. The notice will set out why continuation coverage will be terminated early, the date of termination, and rights, if any, to alternative individual or group coverage.

Continuation coverage may also be terminated for any other reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (such as fraud).

Coverage under COBRA is provided as required by law. If the law changes, your rights will also change.

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Here is a summary of continuation coverage provisions under COBRA.

<table>
<thead>
<tr>
<th>You may purchase continued coverage if you lose coverage because:</th>
<th>For up to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your employment ends or your hours are reduced.</td>
<td>18 months for you and your eligible dependents</td>
</tr>
<tr>
<td>You become entitled to Medicare.</td>
<td>36 months for your eligible dependents</td>
</tr>
<tr>
<td>Your dependent child exceeds the maximum age covered under your Plan.</td>
<td>36 months for your dependent child</td>
</tr>
<tr>
<td>You divorce from your spouse.</td>
<td>36 months for your spouse</td>
</tr>
<tr>
<td>Either you or your ex-spouse remarries and the divorce decree does not provide for coverage under this Plan for your spouse.</td>
<td>36 months for your spouse</td>
</tr>
<tr>
<td>Your death.</td>
<td>36 months for your eligible dependents</td>
</tr>
<tr>
<td>You are disabled for Social Security disability benefit purposes at any time during the first 60 days of COBRA coverage. You must notify the COBRA Administrator in writing within the initial 18-month coverage period and within 60 days of the date of Social Security’s disability determination to be covered on this basis.</td>
<td>29 months for you and your eligible dependents</td>
</tr>
</tbody>
</table>

In the event of your divorce, your eligible children whom you cover under the Plan remain covered for as long as they continue to meet the Plan’s eligibility requirements.

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act of 1974, you may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit. If you and/or your dependents did not elect COBRA during your election period, but are later certified by the DOL for Trade Act benefits or receive pensions managed by the Pension Benefit Guaranty Corporation (PBGC), you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA later than six months after your coverage ended under the Plan.
Also, under the Trade Act eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact. The Plan’s COBRA Administrator may also be able to assist you with your questions.

If You Have Questions
If you have questions about your COBRA continuation coverage, contact the Plan’s COBRA Administrator at 1-888-486-3524. Or you may contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available at www.dol.gov/ebsa.

Keep Your Plan Administrator Informed of Address Changes
In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of you and your family members. You should also keep a copy for your records of any notices you send to the Plan Administrator.

HIPAA Pre-Existing Condition Disclosures
The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes important protections under group medical and dental plans for covered employees and dependents. The law:

- Limits exclusions for pre-existing conditions (the ACA now, however, prohibits group health plans from including limits or exclusions based on pre-existing conditions);
- Prohibits discrimination against Plan participants and dependents based on their health status; and
- Guarantees renewability and availability of health coverage to certain employees and individuals.

HIPAA also guarantees certain important privacy rights. See Privacy and Administrative Information for the Plan’s statement of privacy rights.

Certificate of Creditable Coverage
Health plans are required through December 31, 2014, to provide certification of past coverage, for periods of up to 18 months, to covered employees and/or their dependents who lose coverage under a medical and/or dental plan.

The purpose of the certificate is to show the amount of “creditable coverage” you had under a group health plan or other health insurance coverage because this can reduce or eliminate the length of time that any pre-existing condition clause in a new health care plan might otherwise apply to you.

Because the Health and Welfare Plan does not contain any exclusions or limitations with respect to pre-existing conditions, you do not need to provide a certificate of creditable coverage when you first become eligible for coverage under this Plan. However, a spouse who has had other insurance as primary, upon dropping that other coverage, should provide a HIPAA certificate so that this Plan can coordinate the actual effective date on which this Plan becomes the primary plan.

A certificate will be provided by this Plan through December 31, 2014, if a dependent no longer meets eligibility requirements or if COBRA coverage expires. You can receive a HIPAA certificate for yourself or your dependents upon request, provided you make the request within two years after the coverage terminates.

If you are without health care coverage for 63 days, you will lose any periods of creditable coverage you may have earned under the Plan for purposes of reducing any future pre-existing exclusion period that may apply to you under any new plan.
Qualified Medical Child Support Orders (QMCSOs)

A QMCSO is any court judgment, decree or order, including the approval of a settlement agreement, that creates or recognizes an alternative recipient to be eligible under your Medical, Dental, Prescription Drug or Vision Plan. The Fund recognizes a QMCSO that:

- Provides for child support of your child(ren) under these Plans;
- Provides for health coverage of your child(ren) under state domestic relations law (including a community property law); and
- Relates to benefits under these Plans.

To qualify, a QMCSO must include the name of the Plan to which the order applies.

A QMCSO must not require the Plans to provide any type or form of benefits or option not otherwise provided under the Plans, except to the extent necessary to meet the requirements of section 1908 of the Social Security Act. This section of the Social Security Act relates to the enforcement of state child support laws and reimbursement of Medicaid. Once the Funds Office receives a QMCSO, the Fund will:

- Promptly notify you, as well as each alternative recipient (as defined in section 609(a) (2) (c) of ERISA) that the order covers in writing and each representative of all persons affected by the QMCSO. The notice will include a copy of the order and these QMCSO procedures for determining whether the order qualifies as a QMCSO.
- Permit the alternative recipient(s) to designate a representative to receive copies of notices sent to the alternative recipient relating to the QMCSO.
- Determine, within a reasonable time period after receiving the order, whether it is a qualifying order under the Plans, and notify the appropriate individuals of the determination.
- Ensure that the alternative recipient(s) is treated by the Plans as a beneficiary for ERISA reporting and disclosure purposes, such as by distributing to the alternative recipient copies of the summary plan descriptions and any other relevant plan materials.

If you have any questions about QMCSOs, contact the Funds Office.

Federal Laws That May Affect Your Medical Benefits

Health Insurance Portability and Accountability Act (HIPAA)

In the event that your coverage under this Plan terminates, the Health Insurance Portability and Accountability Act (HIPAA) restricts the right of a new employer or health plan to limit your coverage because of pre-existing conditions, provided that you previously had medical coverage with this Plan. The ACA now prohibits this Plan from limiting your coverage because of pre-existing conditions.

Newborns’ and Mothers’ Health Protection Act

This act requires group health care plans to provide a minimum hospital stay for the mother and newborn child of 48 hours after a vaginal delivery and 96 hours after a cesarean section. Federal law does not, however, prohibit the mother’s or newborn’s attending physician, in consultation with the mother, from determining that a shorter length of stay is appropriate.

The Plan requires admission certification of your maternity stay only if the minimum length of stay (48 or 96 hours, as applicable) is exceeded. A stay exceeding the minimum length requires authorization and is subject to review for medical appropriateness.

Under the Plan, a pregnancy-related hospital stay is treated like an illness, as required by federal law.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Under this Act, participants may have the right to continue their group health care coverage for up to 24 months while they are on a military leave of absence, and may be eligible to have their coverage reinstated if they report for work within a specified period following such leave. For more information about filing for coverage under USERRA, contact the Health and Welfare Fund.
Family and Medical Leave Act (FMLA)
Under this federal law, you may have the right to take up to 12 weeks of unpaid leave for your serious illness, after the birth or adoption of a child, or to care for your seriously ill spouse, parent or child. FMLA leave requires certain employers to maintain health coverage during the leave period.

In addition, under the FMLA, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a military service member. The military service member must:
- Be your spouse, son, daughter, parent or next of kin;
- Be undergoing medical treatment, recuperation or therapy, for a serious illness or injury incurred in the line of duty while in military service; and
- Be an outpatient, or on the temporary disability retired list of the armed services.

If you qualify, during your FMLA leave your medical coverage will be maintained under the Fund. You may be eligible for FMLA leave 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
- Work at a location where at least 50 employees are employed by the employer within 75 miles.

Contributing employers to the Plan are required to continue making contributions to the Plan on your behalf during a qualifying leave of absence under the FMLA.

If you think that this law may apply to you, please contact your employer or the Funds Office.

Women’s Health and Cancer Rights Act
Coverage under a group health care plan for a participant or dependent who is receiving benefits in connection with a mastectomy, who elects breast reconstruction, must include the following benefits in a manner to be determined in consultation with the attending physician and patient, for:
- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all states of the mastectomy, including lymphedemas.

Coverage of breast reconstruction may be subject to deductibles and coinsurance limitations consistent with those established for other medical benefits under the Plan.

Mental Health Parity Acts of 1996 (MHPA) and 2008 (MHPAEA)
Under the original MHPA, group health plans offering mental health benefits could not set annual or lifetime dollar limits on mental health benefits that were lower than such limits under the Plan for medical and surgical benefits. Under the more recent MHPAEA, group health plans offering mental health or substance use disorder benefits are required to apply parity to these benefits consistent with medical or surgical benefits. Financial requirements such as deductibles, co-payments, coinsurance and out-of-pocket expenses, as well as treatment limits on frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment, cannot be different from the same requirements for medical or surgical benefits.

New Mental Health Parity Regulations became effective for the IUOE Local 4 Health and Welfare Plan on January 1, 2012. As of that date the Plan no longer has frequency limits or dollar limits for services related to mental health or substance use disorder benefits. However, services still need to meet medical necessity criteria.
The Affordable Care Act (ACA)

The ACA’s provisions include the following requirements for group health plans:

- Lifetime dollar limits eliminated
- Annual dollar limits on essential health benefits eliminated by 2014
- Pre-existing condition exclusions for children under age 19 eliminated
- Coverage for dependent children extended to age 26 required if dependent, until January 1, 2014, is not otherwise eligible for group coverage through the child’s employer (including through the child’s spouse, if any)
- Rescission or retroactive cancellation of coverage prohibited except for fraud or intentional misrepresentation

No pre-existing condition limitations apply to your coverage under this Health and Welfare Plan. This means that you are covered under this Plan for all eligible services as of the date your coverage begins, subject to the limitations and exclusions described in this SPD.

Disclosure of Early Retiree Reinsurance Program Status

You are a Plan participant in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a federal program that was established under the ACA. Under the Early Retiree Reinsurance Program, the Health and Welfare Plan may choose to use any reimbursements it receives from this program to reduce or offset increases in Plan participants’ premium contributions, co-payments, deductibles, coinsurance or other out-of-pocket costs.

If the Health and Welfare Plan chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a Plan participant, may experience changes that may be advantageous to you in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and the Health and Welfare Plan chooses to use the reimbursements for this purpose.

The Plan may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.
SECTION II: Medical and Prescription Drug Coverage

Medical Plan

The Medical Plan is designed to give you and your family access to high-quality, affordable health care with a choice of physicians, medical facilities and other types of providers. Your share of the cost varies, depending on where you receive care. Although you will have some out-of-pocket costs, you are well protected against catastrophic medical costs while still being covered for more routine care.

Important Note:
Benefits are payable only for eligible participants and only for services that the Plan deems are medically necessary.

To get the most out of the Plan, you should understand how the Plan operates.

If you have questions about eligibility, call the Health and Welfare Funds Office Monday through Friday, 8:00 a.m. to 4:00 p.m., at 1-888-486-3524. If you have questions about benefits or the status of claims, call Blue Cross Blue Shield at 1-800-401-7690. You can also access information about the Plan at www.local4funds.org. Email inquiries are also welcome but should not include protected information such as your Social Security number or any other health plan identification number. Although the Fund uses secure systems, it cannot guarantee the security of incoming systems that are not equally secure.

If you do not follow the Plan’s utilization management procedures, you may pay a penalty or, in some cases, no benefits may be payable at all. To be sure you make the most of your benefits, see the sections of this Plan that apply to your situation before you receive care. See What You Should Know Before You Receive Care, below.

What You Should Know Before You Receive Care

The Medical Plan is a preferred provider organization (PPO) plan through Blue Cross Blue Shield. A PPO is a network of preferred hospitals, doctors and other providers who agree to provide a discount to the Plan and who agree to accept the negotiated rate as payment in full. In Massachusetts the Fund uses the Blue Cross Blue Shield Blue Care Elect PPO Network. The PPO may have a different name in other states.

When you receive care from network providers—providers who participate in the Plan’s preferred network—you receive the highest level of benefits payable under the Plan. Each time you need care, you choose whether to receive care from network or non-network providers. This allows you to choose which providers to use and to control your share of the costs. You always have the final choice as to where you receive care.

If you receive care from a preferred network facility or physician, the Plan pays in-network benefit levels, which are the highest level of benefits available. This means that your share of the cost is lower.

If you receive care from a non-preferred, out-of-network facility or physician, the Plan pays out-of-network benefit levels, a lower level of benefits. This means that you pay a larger share of the cost.

For physicians and other covered professional providers in Massachusetts who do not have a PPO payment agreement with Blue Cross Blue Shield, Blue Cross Blue Shield uses the provider’s charge up to the “usual and customary” charge (also referred to as the “allowed charge”) to calculate your claim payment for most covered services. This “usual and customary” charge, as defined by Blue Cross Blue Shield, is based on the standard fee schedule that Blue Cross Blue Shield has established for its indemnity product participating physicians and other participating professional providers. This usual and customary charge may sometimes be less than the health care provider’s actual charge. If this is the case, you will be responsible for the amount of the covered provider’s actual charge that is in excess of the usual and customary charge. (This is in addition to your deductible and/or your co-pay and/or your coinsurance, whichever applies.)

The Plan’s utilization management provisions apply in many cases, regardless of whether you are receiving in-network or out-of-network care. If you fail to follow these provisions before you receive care, a penalty may apply or, in some cases, no benefit is payable under the Plan. See Utilization Management Requirements for details.
When you require these types of services:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Network Provider</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical, Mental Health and Substance Use Disorder</td>
<td>Blue Cross Blue Shield Blue Care Elect PPO</td>
<td>1-800-401-7690 <a href="http://www.bluecrossma.com">www.bluecrossma.com</a></td>
</tr>
<tr>
<td>Transplants</td>
<td>Blue Distinction Centers for Transplants (BDCT) Network or Blue Cross Blue Shield Blue Care Elect PPO</td>
<td>1-800-401-7690 <a href="http://www.bluecrossma.com">www.bluecrossma.com</a></td>
</tr>
<tr>
<td>EAP (Employee Assistance Program)</td>
<td>Modern Assistance Programs (MAP)</td>
<td>1-617-774-0331 or 1-800-878-2004 or <a href="http://www.modernassistance.com">www.modernassistance.com</a></td>
</tr>
<tr>
<td>Prescription Drug</td>
<td>CVS/Caremark</td>
<td>1-866-273-8408 or <a href="http://www.caremark.com">www.caremark.com</a></td>
</tr>
<tr>
<td>Hearing</td>
<td>EPIC Hearing Health</td>
<td>1-866-956-5400 for benefit information <a href="http://www.epichearing.com">www.epichearing.com</a></td>
</tr>
<tr>
<td>Dental</td>
<td>Delta Dental of MA</td>
<td>1-800-872-0500 or <a href="http://www.deltadentalma.com">www.deltadentalma.com</a></td>
</tr>
<tr>
<td>Vision</td>
<td>Davis Vision</td>
<td>1-800-999-5431 or <a href="http://www.davisvision.com">www.davisvision.com</a></td>
</tr>
</tbody>
</table>

To access a list of Blue Cross Blue Shield preferred network hospitals and/or physicians or other types of providers, go to www.bluecrossma.com or call Blue Cross Blue Shield at 1-800-401-7690. A copy of the network provider list can be given to you free of charge.

Service Area

The Medical Plan service area is nationwide. This means that there are preferred network providers available throughout the United States through all local Blue Cross Blue Shield plans.

Deductibles, Coinsurance and Co-Pays

For most services, you are required to meet a deductible and pay coinsurance (a percentage of the claim) or to not meet a deductible and pay a flat dollar co-pay. When a co-pay applies, generally you will not have to meet a deductible.

If you require hospitalization and wish to receive care at a PPO hospital, ask your doctor to refer you to a network hospital.

Deductible

Your deductible is the amount you must pay each calendar year before benefits are payable under the Plan, as shown in the following chart.

<table>
<thead>
<tr>
<th>Calendar-Year Deductible</th>
<th>In-Network Only</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per individual</td>
<td>$ 200</td>
<td>$ 300</td>
</tr>
<tr>
<td>Per family</td>
<td>$ 400</td>
<td>$ 600</td>
</tr>
</tbody>
</table>

*In-network deductible prior to 1/1/15 is $300 per individual and $600 per family.

Charges for all family members are taken into account when determining whether you have met the calendar-year family deductible, but only $200 of in-network eligible charges per person must be satisfied before benefits are payable for that person.

Assume you are covering yourself, your spouse and two children. If you incur $300 in covered charges, you have met the $200 individual deductible for all care relating to yourself, plus you have contributed $200 toward your family deductible, but you have not met your family deductible. In this case, your spouse and/or children must incur eligible charges of at least $200 before your family deductible is met for the year.

Amounts you pay toward your deductible accrue toward your annual out-of-pocket maximum.
**Coinsurance**

The Plan covers some services that are subject to coinsurance, which is a percentage of the allowed charge. The percentage the Plan does not cover is your responsibility; this amount is called your coinsurance. Services subject to coinsurance are usually subject to the calendar-year deductible. The amount of coinsurance you pay counts toward meeting your annual out-of-pocket maximum.

**Co-Pays**

You are generally required to pay a per-visit co-pay for all in-network services when a deductible does not apply. A co-pay is a set dollar amount. You usually pay a co-pay at the time you receive care. In some cases, a provider will bill you for your co-pay amount after the Plan has paid its share of the cost. Here are some examples of services for which you must pay a co-pay:

- In-network physician office visits (medical care in a provider office including allergy injections);
- In-network physical therapy and chiropractic care; and
- In-network independent labs (not hospital affiliated).

Amounts you pay for medical co-pays count toward your $5,000 annual out-of-pocket maximum.

You may owe more than one co-pay per visit if, for example, you have lab work done as part of an office visit. In this case, the lab and the physician office will each charge a separate co-pay. If you visit a physician who has an office in a hospital, you may incur a co-pay for the physician office visit and coinsurance for any hospital-billed diagnostic X-ray and lab. The calendar-year deductible will apply if the services are not diagnostic X-ray and lab.

Depending on the doctor’s contractual relationship with the hospital, some hospitals also charge you a clinic fee when you visit that physician in the hospital-based or clinic-based office. Your liability for these facility charges may be subject to your calendar-year deductible and coinsurance in addition to your office visit co-pay. Some physicians who have hospital offices also maintain separate, freestanding offices. If you have a choice of where to see your physician, you will usually pay less if you visit your doctor in a freestanding office instead of a hospital. You should discuss this with your doctor to arrange the best plan for your situation.

**Out-of-Pocket Maximum**

Your out-of-pocket maximum is the most you or your family pay for covered medical expenses during a calendar year. Once you reach your out-of-pocket maximum, the Plan pays 100% of covered eligible expenses for the rest of that calendar year.

Your out-of-pocket maximum includes most amounts you and your covered dependents pay for eligible expenses during a calendar year, including your coinsurance amounts. It does not include:

- Prescription co-pays;
- Expenses the Plan does not cover;
- Charges that exceed the reasonable and customary charge for covered services;
- Reductions in benefits and penalties you must pay because you fail to comply with the utilization management provisions; and
- Services with separate, individual benefit maximums, such as Holistic Benefits.

<table>
<thead>
<tr>
<th>If you have:</th>
<th>Your annual out-of-pocket maximum is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single coverage</td>
<td>$5,000</td>
</tr>
<tr>
<td>Family coverage</td>
<td></td>
</tr>
</tbody>
</table>

You may not carry over from year to year amounts you pay toward your annual out-of-pocket maximum.
No Lifetime Benefit Maximum
The Medical Plan no longer has an overall lifetime benefit maximum. Separate maximums and limits apply to certain benefits, as specified in this SPD.

Utilization Management Requirements
Many aspects of the Plan incorporate the benefits of utilization management. The Plan uses the medical policy provisions of Blue Cross Blue Shield of Massachusetts, although Plan benefits may override such provisions. For the Plan to continue to operate efficiently and successfully, you must do your part. This means that you and your covered dependents should comply with all aspects of the Plan’s utilization management provisions.

The utilization management provisions are designed to ensure that you receive the care you need in the most appropriate setting and at the most competitive price.

Before you use your medical benefits, be sure you understand how the Plan’s utilization management provisions work. In many cases, if you do not follow these procedures, you may pay a penalty. In some cases, no benefits are payable if you fail to follow Plan procedures.

Utilization management is the approach that the Plan uses to evaluate the necessity and appropriateness of many different services. This approach employs a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or settings.

These techniques include:
- Pre-authorization review;
- Concurrent review;
- Discharge planning;
- Post-payment review;
- Individual case management; and
- Disease state management.

The Plan’s utilization management policies are designed to encourage appropriate care and services (not less care). The Plan understands the need for special concern about underutilization, and shares this concern with participants and providers.

The Plan does not offer incentives to providers to encourage inappropriate denials of care and services. The Trustees are the final decision makers concerning utilization review and medical necessity.

In addition, review procedures also apply to non-emergency inpatient mental health and substance use care. See Mental Health/Substance Use Disorder Care.

Pre-Authorization Review
All inpatient admissions, partial hospitalizations/intensive outpatient substance use treatment programs, home infusion therapy and home health care must be pre-approved in advance by Blue Cross Blue Shield in order for the services to be covered. (This pre-approval is not required when the inpatient admission is for emergency care or maternity services.) For proposed admissions in an in-network facility, the facility may start the review process for you, but it is your responsibility to ensure that the pre-authorization process takes place.

Blue Cross Blue Shield will contact your physician about the proposed admission, procedure or treatment if more information is needed. In some situations, Blue Cross Blue Shield may arrange an evaluation (usually face to face) with an assessment provider who will assess your specific need and determine if the health care setting is suitable to treat your condition. Usually within two working days of receiving all necessary information, a decision will be made as to whether the health care setting is suitable to treat your condition.
If your physician recommends hospitalization for non-emergency treatment, a partial hospitalization/intensive outpatient treatment program, home infusion therapy or home health care you must follow these steps:

- You or your physician must contact Blue Cross Blue Shield at 1-800-327-6716 before your scheduled admission/treatment.
- Clinical information will be obtained from your physician and the request will be reviewed against clinical criteria.
- You, your physician and the provider/hospital will be notified in writing of the decision regarding your treatment. If the request is approved, you will also be advised of the number of days authorized. In most cases, you will be mailed a written notification on the business day following the completed review.
- If you do not receive written authorization before your scheduled admission/treatment date, call the Plan Administrator at 1-888-486-3524 to be sure your admission/treatment has been approved.

If you do not pre-certify your inpatient admission before you receive care, the Plan may apply a penalty by reducing its payment by $250 or it may deny the admission altogether if the admission is determined not to be medically necessary. You should make every effort to notify Blue Cross Blue Shield as soon as possible after an emergency admission. If an admission is denied, the out-of-pocket costs do not count toward meeting your out-of-pocket maximum. Any recommendations Blue Cross Blue Shield makes during a pre-hospital review are suggestions, not medical advice. While all treatment decisions remain the responsibility of the patient and physician, you may be required to pay the full cost of care if you fail to follow the steps outlined in this section when your physician recommends hospitalization.

Emergency Admissions

If you are admitted to the hospital in an emergency, you, your physician or a family member must call Blue Cross Blue Shield on the first business day after your admission. Blue Cross Blue Shield will then review your admission and confirm in writing the number of authorized hospital days.

Concurrent Review and Discharge Planning

Concurrent review means that while you are an inpatient, Blue Cross Blue Shield will monitor and evaluate the clinical necessity and appropriateness of the health care services you are receiving and make sure you still need inpatient coverage in that facility. In some cases, they may determine that you will need to continue inpatient coverage in that facility beyond the number of days initially thought to be required for your condition.

In other cases, based on medical necessity determination, Blue Cross Blue Shield may determine that you no longer need inpatient coverage in that facility or that you may no longer need inpatient coverage at all. When this is the case, they will call the facility within 24 hours of the coverage determination to let the facility know of the decision and to discuss plans for continued coverage in a health care setting that better meets your needs. For example, your condition may no longer require inpatient coverage in a hospital but still may require skilled nursing coverage. If this is the case, your physician may decide to transfer you to an appropriate skilled nursing facility. Your physician will discuss any proposed plans with you. All arrangements for discharge planning will be confirmed in writing with you.

If you choose to stay in the facility after you have been notified that inpatient coverage is no longer medically necessary, no further benefits will be provided. You must pay all charges for the rest of that inpatient stay, starting from the date the written notification is sent to you.

If you are hospitalized, it is your responsibility to be aware of the number of hospital days approved for your stay and, if extra days are necessary, to confirm with your physician that the Plan has approved them.
**Post-Payment Review**
All of the benefits described in this benefit description will be provided only when they conform to Blue Cross Blue Shield medical technology assessment guidelines. These are guidelines that Blue Cross Blue Shield uses to assess whether a technology improves health outcomes such as length of life or ability to function.

Your claims are reviewed against these guidelines, and if a Blue Cross Blue Shield PPO network provider has not complied with these guidelines, you are held harmless from any denial based on medical necessity. If you receive nonconforming services out-of-network you will be responsible for the full cost.

**Maternity Admissions**
When you are admitted to the hospital for delivery, if unforeseen circumstances require a hospital stay of more than two days for a vaginal delivery or more than four days for a cesarean section, you, your physician or a family member must call Blue Cross Blue Shield for approval of these additional days.

Also, if your newborn stays in the hospital after your discharge you must call to have the medical necessity of your newborn’s continued hospitalization approved.

Benefits are provided for childbirth classes and reimbursed directly to you on a fee schedule basis upon submission of a receipt to Blue Cross Blue Shield. The Blue Cross Blue Shield website at [www.bluecrossma.com](http://www.bluecrossma.com) provides information under its Living Healthy Babies section concerning pre-natal and postnatal care and information on child care.

**Second Surgical Opinion**
If your doctor recommends any elective, non-emergency surgery, the Plan covers a second surgical opinion from any specialist you choose, if you wish to get another opinion. The benefits will be paid at the co-pay or coinsurance level associated with the provider’s contract status and this benefit description. Blue Cross Blue Shield will determine whether your surgery meets clinical criteria.

A benefit under the Plan provides a valuable second opinion service through the Fund’s relationship with Best Doctors. For more information, visit the Best Doctors website at [www.bestdoctors.com](http://www.bestdoctors.com).

**Home Health Care**
When you are hospitalized, you may be able to recover at home, with access to the proper medical assistance. In some cases, you may be able to avoid hospitalization completely. Blue Cross Blue Shield will work with your physician to locate trained health care specialists who can provide necessary medical care in your home.

If your physician determines that you could shorten your stay in the hospital (or avoid hospitalization) if health care services are provided in your home, he or she may call for home health care agency referrals.

If you receive home health care, the home health care agency will work with your physician and the hospital discharge planning staff to develop a treatment plan. Blue Cross Blue Shield is available to review the treatment plan, arrange for home health care services and help ensure a smooth transition.
**Individual Case Management**

Individual case management is a flexible program for managing benefits in some situations. Through this program, Blue Cross Blue Shield works with your health care providers to make sure that you get *medically necessary* services in the least intensive setting that meets your needs. Individual case management is for a patient whose condition may otherwise require inpatient hospital care. Under individual case management, coverage for services, in addition to those described in this benefit description, may be approved to:

- Shorten an *inpatient* stay by sending you home or to a less intensive setting to continue treatment;
- Direct you to an alternative setting when an *inpatient* admission has been proposed; or
- Prevent future inpatient stays by instead providing *outpatient* benefits.

Blue Cross Blue Shield may, in some situations, present a specific alternative treatment plan to your attending physician. This treatment plan will be one that is *medically necessary* for you. Blue Cross Blue Shield will need the full cooperation of everyone involved: the patient (or guardian); the hospital; the attending physician; and the proposed setting or health care provider. Also, there must be a written agreement between the patient (or family or guardian) and Blue Cross Blue Shield, and between the provider and Blue Cross Blue Shield to furnish the services approved through this alternative treatment plan.

*The Trustees reserve the right at any time to request that you undergo an in-depth medical exam to determine that your treatment is medically necessary.*

If you or a family member is seriously ill or injured, Blue Cross Blue Shield is available to work with you, your family and your physician to develop an effective long-term treatment plan.

If you qualify for individual case management, Blue Cross Blue Shield monitors your progress, coordinates delivery of services and provides information about available treatment alternatives.

**Disease State Management**

Disease state management is a voluntary program designed to assist individuals diagnosed with specific chronic health conditions. Patients who participate in the program are assigned a care manager who provides educational materials, locates community resources and answers questions relating to the disease. Additionally, care managers work with attending physicians to coordinate a patient’s care.

Among other conditions, the Blue Cross Blue Shield disease state management program currently includes the following chronic diseases:

- Asthma and COPD;
- Diabetes;
- Heart failure/coronary artery disease;
- Chronic renal failure;
- Low back pain;
- Cystic fibrosis;
- Multiple sclerosis;
- Parkinson’s disease; and
- Rheumatoid arthritis.

If you have been diagnosed with one of these conditions or any other chronic condition, you may be contacted about participating in a voluntary program.

*Disease state management is a voluntary program. No penalty applies if you choose not to participate.*

**How to Appeal a Utilization Management Decision**

If you disagree or your physician disagrees with a decision regarding hospital admission, partial hospitalization, case management, or an outpatient procedure or treatment, you may appeal the decision by following the process outlined in *How to File Claims and Appeal Denied Claims.*
Utilization Management Checklist

Use this checklist to realize maximum benefits from the Medical Plan.

- Get prior authorization from Blue Cross Blue Shield for all non-emergency, non-maternity hospital admissions or partial day/intensive substance use outpatient treatment.
- Have your physician or a family member call Blue Cross Blue Shield on the first business day after an emergency hospital admission.
- If you require a maternity hospitalization beyond the standard number of days, or if your newborn requires continued hospitalization after you are discharged, call Blue Cross Blue Shield for approval.
- Request prior authorization for home health care or home infusion services.

For questions about how a particular procedure is covered, or whether a hospital or other provider belongs to a network, contact Blue Cross Blue Shield. For questions about eligibility, contact the Funds Office.

Medical Plan Benefit Chart

Covered services include but are not limited to those listed here. All benefits are subject to specific limitations, coinsurance, deductibles, exclusions and specified payment maximums as described elsewhere in this SPD and subject to the medical policy provisions of Blue Cross Blue Shield of Massachusetts.

<table>
<thead>
<tr>
<th>Calendar-Year Deductible (does not apply to services that are subject to a co-pay)</th>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• $300 per individual/$600 per family (applies to in-network and out-of-network covered services combined) prior to 1/1/15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• $200 per individual/$400 per family (in-network) as of 1/1/15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• $300 per individual/$600 per family (out-of-network) as of 1/1/15</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calendar-Year Out-of-Pocket Maximum (includes coinsurance, deductible and medical co-pays)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Once you pay $5,000 in coinsurance, deductible, and medical co-pay costs per individual or family, you receive 100% coverage for most services subject to coinsurance for the balance of the year. Services subject to specific limits, such as Holistic Benefits, do not count toward the out-of-pocket maximum.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acute Hospital Facility Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Admissions for Medical and Surgical Care (including maternity)</td>
<td></td>
</tr>
<tr>
<td>Room and board (up to the average semi-private room rate), intensive care confinement, and all ancillary and special services billed by the hospital</td>
<td></td>
</tr>
<tr>
<td>Admissions (other than maternity) must be preauthorized by Blue Cross Blue Shield</td>
<td></td>
</tr>
<tr>
<td>Maternity Admissions</td>
<td></td>
</tr>
<tr>
<td>You do not need to pre-authorize your normal maternity hospital admission. You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. An extended maternity admission is covered if medically necessary and pre-authorized. Covered services include well newborn care, routine circumcision, and semi-private room and board and special services for the mother and newborn. Newborn hearing screening tests covered to age 3 months with $15 co-pay in-network; 30% coinsurance after deductible out-of-network.</td>
<td></td>
</tr>
</tbody>
</table>

10% coinsurance after you pay your deductible

30% coinsurance after you pay your deductible; 10% coinsurance after deductible if Blue Cross Blue Shield determines the admission is a medical emergency.
All Admissions
Inpatient ancillary charges billed by a hospital include: use of operating rooms and other surgical treatment rooms; use of recovery and delivery rooms; anesthesia and its administration (when administered by an employee of the hospital); diagnostic lab and X-ray services; chemotherapy and radiation therapy; radium, radioactive isotopes and X-ray therapy; renal dialysis; medical supplies such as casts, splints and trusses; blood or blood plasma and its administration; oxygen and equipment for its administration; use of durable medical equipment while you are in the hospital such as inhalators, suction machines, respirators, oxygen tents and hyperbaric oxygen chambers; drugs and medicines you receive while you are an inpatient; and physiotherapy. Private rooms are covered only if you must be isolated to prevent contagion.

If you do not pre-authorize your inpatient admission before you receive care, the Plan may deny your admission, if it is later determined not to have been medically necessary. You should make every effort to notify Blue Cross Blue Shield as soon as possible after an emergency admission.

The Plan will not cover services determined to be medically unnecessary. If it is determined that your admission to the hospital is not medically necessary, your claim will be denied. If this occurs, you will be responsible for the full cost of your care, and amounts you pay for such services will not count toward meeting the out-of-pocket maximum.

Outpatient Facility Care
Includes outpatient facility charges and medical services billed by the outpatient department of a facility including: chemotherapy and radiation therapy; renal dialysis; IV therapy; cardiac rehabilitation; ambulatory surgery; emergency medical services; medical and surgical supplies; therapeutic radiology; CT, MRI and other scans; and physical therapy. (Does not include outpatient diagnostic lab and X-ray.)

<table>
<thead>
<tr>
<th></th>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td>10% coinsurance after you pay your deductible</td>
<td>10% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>Facility and physician charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory or Inpatient Surgery</td>
<td>10% coinsurance after you pay your deductible</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>Surgical day care unit of a hospital or freestanding ambulatory surgical facility or as an inpatient. Inpatient procedures must be pre-authorized by Blue Cross Blue Shield and other care must meet Blue Cross Blue Shield medical policy guidelines.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Covered surgical procedures include: routine circumcision of an infant; voluntary sterilization procedures; termination of pregnancy only to prevent the death of the mother; endoscopic procedures; cataract surgery; and surgical procedures (including emergency and scheduled surgery). These surgical services include (but are not limited to): the incision, excision or electrocauterization of any part of the body; the manipulative redirection of a fracture or dislocation; the suturing of a wound; or the removal by endoscopic means of a stone or other foreign object from the body. If two or more procedures are performed during the course of a single operation through the same incision, or in the same operative field, eligible charges for the additional procedures will be reduced by 50%. An assistant surgeon's eligible charges shall not exceed 20% of the primary surgeon's eligible charge.

Reconstructive surgery is non-dental surgery that is meant to improve or give back bodily function or correct a functional physical impairment that was caused by a birth defect, a prior surgical procedure or disease or an accidental injury. This also includes surgery to correct a deformity or disfigurement that was caused by an accidental injury. This includes reconstructive surgery for a mastectomy and election of breast reconstruction in connection with the mastectomy. As required by federal law, these benefits are provided for: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending physician and patient.

### Ambulance

<table>
<thead>
<tr>
<th>Ambulance service for medically necessary transport to the nearest facility equipped to provide the service required</th>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% coinsurance after you pay your deductible</td>
<td>30% coinsurance after you pay your deductible, or 10% coinsurance after you pay your deductible if medical emergency</td>
<td></td>
</tr>
</tbody>
</table>

### Extended Care Facility

<table>
<thead>
<tr>
<th>Extended Care Facility Inpatient care in a skilled nursing facility and/or rehabilitation hospital for skilled services limited to 100 days per calendar year; must be pre-authorized by Blue Cross Blue Shield</th>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% coinsurance after you pay your deductible and amounts above per-admission limits</td>
<td>30% coinsurance after you pay your deductible and amounts above per-admission limits</td>
<td></td>
</tr>
</tbody>
</table>

If you require skilled nursing care or rehabilitation care, but not the extensive technological support of an acute care hospital, the Plan covers your inpatient care in an extended care facility. An extended care facility is an institution (or part of an institution) licensed to provide convalescent or skilled nursing care to resident patients and is or could be certified as an extended care facility under Medicare.

Extended care facility benefits will be restored for each new period of confinement. A new period of confinement begins at least 60 days after your last confinement. To be eligible for extended care facility benefits, you must be admitted to the extended care facility for non-routine care at the recommendation and under the supervision of your physician, and services must be preauthorized by Blue Cross Blue Shield.
## Home Health Care

To be covered under the Plan, home health care must be:
- Under the order and direct supervision of your physician;
- In lieu of continued hospital or extended care facility services;
- Furnished by a licensed home health care agency, a hospital or a licensed visiting nurse association; and
- Pre-authorized by Blue Cross Blue Shield.

When you meet these requirements, the Plan covers the following home health care services:
- Part-time (less than an eight-hour shift) skilled nursing visits by a registered nurse (RN) or licensed practical nurse (LPN), but not by someone who is a family member or resident of your household;
- Medical social work;
- Physical therapy, speech/language therapy (to restore speech to someone who has lost existing speech function as the result of a disease or injury) and occupational therapy;
- Nutritional consultation services;
- Part-time or intermittent home health aide services provided by a home health aide and under the supervision of an RN (up to four hours per visit);
- Medical supplies and equipment suitable for home use; and
- Enteral infusion therapy and basic hydration therapy furnished by a coordinated home health agency, including the infusion solution, preparation of the solution and equipment for its administration and the necessary part-time nursing furnished by a home infusion therapy provider.

These benefits are provided only when the patient is expected to reach a defined medical goal set by the patient’s attending physician and, for medical reasons, the patient is not reasonably able to travel to another treatment site where medically appropriate care can be furnished for the patient’s condition. No benefits are provided for meals, personal comfort items and housekeeping services; custodial care; private duty nursing; or treatment of mental conditions.

## Hospice Care

Hospice care is an alternative to hospital confinement, designed to meet the physical and emotional needs of the terminally ill patient and his or her family. Hospice care aims to help both the patient and family cope with terminal illness and to control its pain and symptoms. Hospice care benefits are available to patients who are diagnosed as terminally ill and have six or fewer months to live, and services must be pre-authorized by Blue Cross Blue Shield. Hospice care may be delivered in the patient’s home, in a specialized hospice care center or by a hospital.

Inpatient hospice care benefits are payable when there are no suitable caregivers available to provide home hospice care and it is determined by the hospice agency that home hospice care is impractical because the patient is unmanageable by the persons who regularly assist with home care. Inpatient hospice care is also payable for respite care, which allows short-term inpatient stays necessary for the patient to give temporary relief to a caregiver who regularly assists with home care. Inpatient respite care is limited to individual stays of no more than five consecutive days.
### Professional Care (services billed by physician’s office)

<table>
<thead>
<tr>
<th></th>
<th>YOUR COST IN-Network</th>
<th>YOUR COST OUT-OF-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Office Visit (office or hospital setting)</strong></td>
<td>$15 co-pay; $10 co-pay as of 6/1/15</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
</tbody>
</table>

Covered services include: evaluation and management codes billed by a physician; in-office consultations; second surgical opinion; immunizations; allergy serum and injections; in-office surgery; and machine tests, when performed in the office.

You may incur additional charges for diagnostic lab and X-ray services if they are billed on a different date or by another provider, or if your physician refers you to a hospital or an out-of-network provider.

Flu shots performed as a stand-alone procedure incur no co-pay when performed in-network.

Visits to a nurse practitioner or physician assistant at a CVS MinuteClinic are covered at no cost to you. To find a MinuteClinic near you, and to learn more about the services offered, go to [www.cvs.com/minuteclinic](http://www.cvs.com/minuteclinic).

### Preventive Care

| Routine Adult Physical | **Covered annually** | **You may incur additional charges for diagnostic lab or X-ray services if they are billed on a different date or by another provider.** | **No cost to you** | **30% coinsurance after you pay your deductible** |

Participants may substitute their Department of Transportation (DOT) physical in lieu of their covered physical. The following preventive services are covered annually for adults:

- History and risk assessment;
- Chest X-ray;
- EKG;
- Urinalysis;
- Basic and comprehensive metabolic panel;
- Complete blood count;
- Fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides);
- Chlamydial infection test;
- Fecal occult blood test;
- Prostate specific antigen test; and
- Routine immunizations including hepatitis (type A and B) for patients with increased risk or family history, influenza and pneumococcal vaccines, Lyme disease, and tetanus-diphtheria (Td) booster (once every 10 years). Flu shots performed as a stand-alone procedure incur no co-pay when performed in network.

Cancer screening via sigmoidoscopy (every five years) or colonoscopy (every 10 years) is covered after age 50. The Plan covers these services as a hospital and/or surgical benefit, but the deductible and co-pay are waived when the services are billed as routine screening services. Routine PSA blood test (every year) is covered after age 40.
### Routine Child Physical
Covered based on this schedule:
- Birth to 12 months: six visits per year
- 12 to 24 months: three visits per year
- 24 months to age 19: one visit per year

You may incur additional charges for diagnostic lab or X-ray services if they are billed on a different date or by another provider.

The following preventive care services are covered as part of a routine child physical:
- Medical history;
- Physical examination;
- Measurements;
- Sensory screening;
- Assessments;
- Hereditary and metabolic screening (at birth only);
- Appropriate immunizations;
- Tuberculin tests; and
- Hematocrit, hemoglobin or other appropriate blood tests.

<table>
<thead>
<tr>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>No cost to you</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
</tbody>
</table>

### Routine Gynecological Exam
Covered annually beginning at age 16

<table>
<thead>
<tr>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>No cost to you</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
</tbody>
</table>

### Medical and Surgical Care

#### Physician Inpatient or Outpatient Medical Care
When you receive physician services at a hospital or in an emergency room

<table>
<thead>
<tr>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% coinsurance after you pay your deductible</td>
<td>30% coinsurance after you pay your deductible, or 10% coinsurance for emergency room services determined to be a medical emergency</td>
</tr>
</tbody>
</table>

#### Physician Maternity Care
Includes global maternity fee for most pre-natal and inpatient care

<table>
<thead>
<tr>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% coinsurance after you pay your deductible</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
</tbody>
</table>

Laboratory tests that are part of your pre-natal care are covered after a $10 co-pay when received from a Blue Cross Blue Shield contracted independent lab or physician office. Pre-natal lab work processed through a preferred hospital is covered after the 10% coinsurance without application of the deductible. Birthing centers are covered at the same level as inpatient hospital benefits. Childbirth education classes are reimbursed based on a fee schedule (contact Blue Cross Blue Shield for details). Family planning services for contraception are covered under the office visit benefit. Voluntary sterilization is covered after a co-pay when performed in-office or after the deductible and coinsurance if performed in a facility. The Plan does not cover routine screening ultrasounds; maternity ultrasounds must be medically necessary to be covered. Midwives are covered only in a birthing center.
<table>
<thead>
<tr>
<th>Physician Surgery Care</th>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient or outpatient, including charges for surgery, anesthesia, surgical pathology, supplies, casts and diagnostic testing performed as part of a surgical procedure performed at a hospital or an ambulatory surgical facility</td>
<td>$10 co-pay</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
</tbody>
</table>

The Plan covers charges for services of a licensed surgeon, assistant surgeon and anesthetist for a surgical procedure involving the:

- Incision, excision or electro-cauterization of any part of the body;
- Manipulative redirection of a fracture or dislocation;
- Suturing of a wound; or
- Removal by endoscopic means of a stone or other foreign object from the body.

If two or more procedures are performed during the course of a single operation through the same incision, or in the same operative field, eligible charges for the additional procedures will be reduced by 50%. An assistant surgeon's eligible charge shall not exceed 20% of the primary surgeon's eligible charge.

Covered surgery benefits also include: biopsy of tumors and cysts; voluntary sterilization; circumcision of newborn; correction of congenital (non-dental) anomalies; treatment of burns; insertion of prosthetic devices; assistant surgeon if complexity requires one; dental surgery related to an accidental injury (other than chewing); gastric bypass, if you meet clinical requirements; initial placement of contact lenses or initial lens implant required because of cataract surgery; and surgery related to temporomandibular joint (TMJ) disorders. Routine screening colonoscopy or routine screening sigmoidoscopy services are excluded from application of the calendar-year deductible.

If you receive care in a PPO network hospital from a non-contracting radiologist, anesthesiologist, pathologist or emergency room physician, your services are covered at the in-network rate, since you have no control over who treats you in these situations. Contact Blue Cross Blue Shield if your claim has not been processed at the in-network level of benefits in this situation.

<table>
<thead>
<tr>
<th>Lab and X-Ray</th>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab or X-Ray</td>
<td>$10 co-pay</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>In-office charges billed by your physician (on a date different from your office visit)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lab or X-Ray</th>
<th>$10 co-pay</th>
<th>30% coinsurance after you pay your deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billed by an independent lab or X-ray facility</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lab or X-Ray</th>
<th>No cost to you</th>
<th>30% coinsurance after you pay your deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billed by any provider or facility as part of a covered physical</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lab or X-Ray</th>
<th>10% coinsurance only, no deductible applies (see the next page for the definition of diagnostic lab and X-ray services)</th>
<th>30% coinsurance after you pay your deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billed by the outpatient department of a hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Description</td>
<td>Your Cost In-Network</td>
<td>Your Cost Out-of-Network</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Lab or X-Ray</td>
<td>10% coinsurance after you pay your deductible</td>
<td>30% coinsurance after you pay your deductible, or</td>
</tr>
<tr>
<td>Billed by an emergency room, emergency room physician,</td>
<td></td>
<td>10% coinsurance after deductible for emergency room</td>
</tr>
<tr>
<td>ambulatory surgery facility, surgeon or anesthetist, or billed when you are an</td>
<td></td>
<td>services</td>
</tr>
<tr>
<td>inpatient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Covered diagnostic lab and X-ray services include the following types of services when billed by the outpatient department of a hospital: laboratory services; X-rays; ultrasound imaging; bone density tests; machine tests; and follow-up mammography. Covered services in this category do not include MRI or PET scans.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Mammogram</td>
<td>No cost to you</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>Imaging and radiologist review charges, when performed at any site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered annually after age 35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Pap Test</td>
<td>No cost to you</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>Laboratory charges when performed at any site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI and PET Scans</td>
<td>No cost to you</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Imaging charges billed by Shields Health Care Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI and PET Scans</td>
<td>No cost to you</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>Imaging charges by freestanding sites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI and PET Scans</td>
<td>No cost to you</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>Imaging charges in outpatient department of hospital</td>
<td>10% coinsurance after calendar-year deductible</td>
<td>30% coinsurance after calendar-year deductible, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% coinsurance after deductible in emergency room</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>YOUR COST IN-NETWORK</td>
<td>YOUR COST OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hospitalization and Physician Care</td>
<td>No cost when received in a Blue Distinction Centers for Transplants (BDCT) facility</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>Services that are pre-authorized by Blue Cross Blue</td>
<td>10% coinsurance after you pay your deductible when services are delivered by a PPO</td>
<td></td>
</tr>
<tr>
<td>Shield are covered when related to the following</td>
<td>network hospital and physician not in the BDCT Network</td>
<td></td>
</tr>
<tr>
<td>human-to-human organ or tissue transplants: heart;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lung; heart-lung; liver; kidney; pancreas (when the</td>
<td></td>
<td></td>
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<tr>
<td>condition is not treatable by insulin therapy);</td>
<td></td>
<td></td>
</tr>
<tr>
<td>kidney-pancreas; bone marrow (for leukemia); cornea;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and skin and bone.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ Procurement From Living and Non-Living Donors</td>
<td>No out-of-pocket cost and no limit on procurement costs when services are received</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td></td>
<td>through the BDCT Network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10% coinsurance after you pay your deductible when delivered by a PPO network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>hospital and physician not in the BDCT Network</td>
<td></td>
</tr>
<tr>
<td>Transportation and Lodging of Patient and Accompanying</td>
<td>Up to $200 per day, up to $10,000 per transplant through the BDCT Network</td>
<td>Not covered</td>
</tr>
<tr>
<td>Family Members (one for adult, two for minor child)</td>
<td>Not covered except through the BDCT Network</td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Two of each transplant type</td>
<td></td>
</tr>
</tbody>
</table>

The Blue Distinction Centers for Transplants (BDCT) Network provides broad coverage for organ and tissue transplants through access to a network of top-quality providers. These medical institutions are selected for the BDCT Network based on the expertise of their surgical teams and the state-of-the-art facilities they maintain. Your participation in the BDCT program is completely voluntary. Should you or an eligible dependent need an organ or tissue transplant and wish to participate in the BDCT program, you or your physician should contact Blue Cross Blue Shield. Facility network information is available through Blue Cross Blue Shield. The Plan covers the following expenses associated with transplant surgery, when alternative remedies are not available:

- The use of temporary mechanical equipment, pending the acquisition of a matched human organ;
- Multiple transplants during one operative session;
- Replacement or subsequent transplant; and
- Follow-up expenses for covered services, including immunosuppressant therapy.

The Plan covers recipient expenses. A recipient is an individual who undergoes a surgical operation to receive a body organ transplant. Benefits for donor expenses are limited to donors who donate an organ to recipients who are covered under this Plan.
The following special limitations apply to the organ transplant benefit:

- The Plan does not cover organ transplant services considered to be experimental or investigational. For details see *What the Medical Plan Does Not Cover* or see *Important Terms* for a definition of experimental and investigational.
- If both the donor and recipient are covered under this Plan, the Plan covers eligible medical expenses incurred by the donor.
- If the donor has no medical insurance coverage, this Plan will cover 100% of the charges for care received through the BDCT Network.
- If the donor has medical insurance but donor expenses are excluded under that coverage, this Plan will cover 100% for care received through the BDCT Network.
  - If both the donor and recipient are covered under this Plan, eligible medical expenses incurred by each person are treated separately.
- The Plan covers the reasonable and customary cost of securing an organ from a cadaver or tissue bank, including the surgeon’s charge for removing the organ and the hospital’s charge for storing or transporting the organ.
- Immunosuppressive therapy is covered.

See *What the Medical Plan Does Not Cover* for other limitations or exclusions.

### Cardiac Rehabilitation

#### Outpatient Cardiac Rehabilitation Service

Includes Phase II and III of a multi-phasic program for persons with documented cardiovascular disease

<table>
<thead>
<tr>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% coinsurance after you pay your deductible</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
</tbody>
</table>

When provided in a hospital or other setting that meets the standards of the Massachusetts Commission of Public Health or a comparable health commission in another state, outpatient cardiac rehabilitation services are covered at the same level as other outpatient hospital services.

Covered cardiac rehabilitation services include Phases II and III of a multi-phasic program for persons with documented cardiovascular disease. This program provides medically necessary treatment designed to restore the patient to optimal physiological health.

- Phase I is the inpatient phase, which begins at the time of the cardiac event and continues through hospital discharge. Benefits for Phase I are covered under the inpatient hospital care portion of the Plan.
- Phase II is the outpatient convalescent phase that begins after hospital discharge and usually extends for a period of three to 12 weeks.
- Phase III is the outpatient phase that addresses multiple risk reduction, adjustment to illness and therapeutic exercise. Phase III follows the convalescent phase and usually extends for a period of 12 to 26 weeks.

The Plan does not cover Phase IV benefits, which are designed to maintain rehabilitated cardiovascular health.

To be covered, treatment must begin within 26 weeks after the diagnosis of cardiovascular disease or an event related to cardiovascular disease. An event related to cardiovascular disease includes, at a minimum:

- Angioplasty;
- Cardiovascular surgery; or
- Myocardial infarction.
### Physical Therapy

**Physical Therapy**  
Must be prescribed by a physician and performed by a licensed physical therapist or physician

<table>
<thead>
<tr>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15 co-pay; $10 co-pay as of 6/1/15</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>$15 co-pay; $10 co-pay as of 6/1/15</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>$15 co-pay; $10 co-pay as of 6/1/15</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
</tbody>
</table>

Covered physical therapy is intended to provide rehabilitation to regain normal movement and strength. The Plan does not cover the following services: recreational or educational therapy; maintenance or palliative rehabilitation therapy; programs due to developmental delay or early intervention; applied behavior analysis; exercise programs; or hippotherapy (exercise on horseback). Occupational therapy services are covered to the same extent and limitation as physical therapy services.

### Chiropractic

**Chiropractic Care and Acupuncture**  
Coverage is limited to 20 visits per service per year

<table>
<thead>
<tr>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15 co-pay and amounts above your calendar-year maximum; $10 co-pay as of 6/1/15</td>
<td>30% coinsurance after you pay your deductible for chiropractic care</td>
</tr>
<tr>
<td>$15 co-pay and amounts above your calendar-year maximum; $10 co-pay as of 6/1/15</td>
<td>30% coinsurance after you pay your deductible for acupuncture visit; $10 co-pay as of 6/1/15</td>
</tr>
</tbody>
</table>

To be covered under the Plan, chiropractic services must be rendered by a board-certified chiropractor (DC) and services (including diagnostic services and all other treatments) must be medically necessary to treat an illness or injury.

### Alternative Care (Holistic Medicine)

**Acupressure, Homeopathy, Massage Therapy**  
Coverage is limited to $1,000 per calendar year for the services listed above

<table>
<thead>
<tr>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15 co-pay and amounts above your calendar year maximum; $10 co-pay as of 6/1/15</td>
<td>$15 co-pay and amounts above your calendar year maximum; $10 co-pay as of 6/1/15</td>
</tr>
</tbody>
</table>

Covered providers must be licensed in the state where they are rendering care and carry malpractice insurance. There are times when the Plan will require you to seek a referral from a licensed physician in order to approve treatment. You must file a claim for reimbursement of alternative care treatments. Claim forms can be obtained by contacting Blue Cross Blue Shield or by accessing the Funds’ website.

You may have to file your own claim to be reimbursed for alternative care benefits. Alternative care does not include naturopathic medicine; hormone, hair, saliva or fecal testing; supplements and minerals; or services not rendered by an MD unless services are acupressure, homeopathy or massage therapy.
<table>
<thead>
<tr>
<th></th>
<th>YOUR COST IN-NETWORK</th>
<th>YOUR COST OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment and Prosthetic Appliances</td>
<td>10% coinsurance after you pay your deductible</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>Purchase, or rental up to the purchase price</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amounts you pay for these services do not count toward your annual out-of-pocket maximum.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment must serve a medical purpose and have no other essential value in the absence of an illness or injury. Equipment must meet Blue Cross Blue Shield medical policy guidelines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered services include: non-dental braces; canes; crutches; commodes; wheelchairs; artificial limbs and eyes; breast protheses and surgical bras following mastectomy; oxygen and equipment for its administration; inhalators; suction machines; respirators; hyperbolic oxygen chambers; breast pumps; insulin pumps; continuous glucose monitor and glucose monitor sensors; and CPAP machines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Replacement of artificial limbs and eyes limited to prescription change or the appliance must be over five years old.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>These benefits are provided for the least expensive equipment of its type that meets the patient need. If Blue Cross Blue Shield determines that the patient chose a prosthesis or other equipment that costs more than what the patient needs for his or her medical condition, benefits are provided only for those charges that would have been paid for the least expensive prosthesis or equipment that meets the patient need. In this case the patient must pay the provider’s charges that are more than the claim payment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical and Surgical Supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical and Surgical Supply Charges including: bandages and casts; splints; surgical trays; therapeutic or diagnostic infusion supplies; and ostomy and catheter supplies (bandages, splints and casts provided as part of the physician office visit are covered under the office visit co-pay)</td>
<td>10% coinsurance</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Use Disorder Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Mental Health Facility Charges</td>
<td>10% coinsurance</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>Inpatient Substance Use Facility Charges</td>
<td>10% coinsurance</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>Inpatient Mental Health Professional Charges</td>
<td>10% coinsurance</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>Inpatient Substance Use Professional Charges</td>
<td>10% coinsurance</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>Outpatient Mental Health Counseling In-office or hospital outpatient</td>
<td>$15 co-pay in the office; $10 co-pay as of 6/1/15</td>
<td>30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>Medical and Prescription Drug Coverage</td>
<td>DENTAL, VISION AND HEARING COVERAGE</td>
<td>LIFE AND DISABILITY INSURANCE</td>
</tr>
<tr>
<td>----------------------------------------</td>
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<td>-------------------------------</td>
</tr>
<tr>
<td><strong>Partial Day Hospitalization/Intensive Outpatient Services (IOP)</strong>&lt;br&gt;These services are used in lieu of full inpatient care&lt;br&gt;These services use an inpatient setting but the patient is discharged to home at the conclusion of each day of care</td>
<td><em>YOUR COST IN-NETWORK</em>&lt;br&gt;$15 co-pay; $10 co-pay as of 6/1/15</td>
<td><em>YOUR COST OUT-OF-NETWORK</em></td>
</tr>
<tr>
<td><strong>Neuro-Psych Testing</strong>&lt;br&gt;In-office or hospital outpatient</td>
<td><em>YOUR COST IN-NETWORK</em>&lt;br&gt;$15 co-pay; $10 co-pay as of 6/1/15</td>
<td><em>YOUR COST OUT-OF-NETWORK</em>&lt;br&gt;30% coinsurance after you pay your deductible</td>
</tr>
<tr>
<td>Neuro-psych testing is not covered in the following situations: for the routine diagnosis of ADHD, for learning disorders or educational purposes, or for evaluation or diagnosis of developmental delay</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Employee Assistance Program (EAP), administered by Modern Assistance Program (MAP)</strong></td>
<td>No cost when using EAP services through MAP</td>
<td></td>
</tr>
</tbody>
</table>

The Employee Assistance Program (EAP) provides a qualified and confidential source of help for participants experiencing personal problems. In many instances, you may resolve these problems without the services of the EAP. Sometimes, however, it may be in your best interest to seek outside assistance. EAP benefits are available to you and your eligible dependents at no charge. Any calls you make to the EAP are completely confidential. Under no circumstances will your name or information about your situation be passed on to your employer or the Union office.

While the EAP may not solve your problems, it is a reasonable place to start dealing with problems that may be overtaking your life. For several major problems and conditions, skilled and experienced professionals are available to help. You can call the EAP at Modern Assistance Programs, Inc., for a broad range of problems including:

- Stress;
- Anxiety;
- Depression;
- Marital problems;
- Family counseling;
- Financial difficulties; and
- Alcohol and drug abuse.

EAP counselors are available during regular business hours; night and weekend support is available through a counselor on call. The local EAP counselor will meet with you, generally up to three times, to assess your situation and make recommendations. If necessary, the EAP counselor may refer you to another professional for further assistance. EAP services are entirely voluntary.

For more information about the EAP, call MAP at 1-617-774-0331 or 1-800-878-2004.
What the Medical Plan Does Not Cover

1. Confinement, surgical procedures or treatments that occur before the effective date of coverage. The Plan does cover confinements, surgical procedures or treatments as of the effective date of coverage, regardless of when treatment began.

2. Any job-related accidents or illnesses which Workers’ Compensation would cover, regardless of whether such coverage was in force or whether you applied for or received Workers’ Compensation benefits.

3. Services to the extent that payment under the Plan is prohibited by any law to which any employee or family member is subject at the time expenses were incurred.

4. Charges which would not have been incurred had the coverage not existed or charges for services rendered by parents, siblings, spouses, children or children-in-law.

5. Charges in excess of what is reasonable and customary for the locality in which services are performed or in excess of the Plan’s negotiated fees, if lower.

6. Charges in connection with custodial care, learning disorders, educational evaluations, early intervention programs or developmental delays.

7. Plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies that improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to improve the function of a part of the body that is:
   - A result of a severe birth defect;
   - A direct result of disease or surgery previously performed; or
   - To treat a disease or injury.

8. Eyeglasses, hearing aids, or examinations for prescription or fitting, unless otherwise stated (see Vision Plan for information on vision care benefits and Hearing Plan for information on hearing care benefits).

9. Dental treatment or services, unless the expense is the result of an injury to sound, natural teeth (other than chewing) as a result of injury (see Dental Plan for information on dental benefits).

10. Routine foot care including treatment for weak, strained, unstable and flat feet; bunions (unless cutting procedures are involved); and cutting or removal of corns and calluses.

11. Expense of travel except when specifically covered under the organ transplant program.

12. Any expense or charge that results from an act of declared or undeclared war.

13. Any expense or charge resulting from commission of a felony or attempt to commit a felony unless the injuries are the result of a medical condition or unless the covered person is a victim of the commission of a felony or attempt to commit a felony or the victim of domestic violence.

14. Any expense for care, services and supplies that are not medically necessary or not recommended by a physician.

15. Any expense in connection with the pregnancy of dependent children prior to January 1, 2011.

16. Any expense in excess of the former limitations under the mental health and substance use disorder benefits incurred prior to January 1, 2012.

17. Any expense for treatment or diagnosis of infertility, artificial insemination, in-vitro fertilization, or embryo transfer procedure or any other artificial method of conception.

18. Nutritional and mineral supplements and vitamins, unless otherwise stated.

19. Wigs or hair prostheses, unless prescribed due to loss of hair resulting from chemotherapy or radiation therapy.

20. Any special diets or nutritional counseling, regardless of whether prescribed by a physician, unless as the result of illness or injury or otherwise stated.

21. Any expense for experimental treatment still under clinical investigation by health professionals and determined as not covered by Blue Cross Blue Shield of Massachusetts Medical Policies. The fact that the experimental treatment is the only available treatment for a particular condition will not result in benefits if the procedure or treatment is considered to be experimental or still under clinical investigation. A case-by-case exception can be made to consider coverage of medically necessary diagnostic tests such as laboratory, pathology, or X-ray services or office visits that are not otherwise covered when provided under a qualified clinical trial (see Important Terms for a definition of experimental or investigative.)

22. Any expense for acupuncture, acupressure, homeopathy or massage therapy, unless the provider is licensed in the state in which he or she practices and carries malpractice insurance.
23. Any expense for or in connection with sex transformations or any treatment related to sexual dysfunction.

24. Charges levied by a physician for his or her time spent traveling, for broken appointments, for transportation costs, or for advice given by telephone or other means of communication.

25. Surgery that is intended to allow you to see better without glasses, or other vision correction including radial keratotomy, laser and other refractive eye surgery (see Vision Plan for information on vision care benefits).

26. Corrective shoes, orthotics, or pillows and any other supportive devices for the feet or back.

27. Any expenses in connection with appetite control or any treatment of obesity, except for surgery to treat morbid obesity, when the patient meets the Blue Cross Blue Shield criteria; morbid obesity is defined as being more than 100 pounds over normal weight for at least five years.

28. Abortion, unless the life of the mother would be in danger if the fetus were carried to full term.

29. The reversal of voluntary sterilization.

30. Durable medical equipment for non-medical use (regardless of whether prescribed by a physician), such as heating pads, whirlpool baths, exercise equipment or devices, ramps or handrails, air conditioners, purifiers, humidifiers, or items of furniture.

31. Any expense incurred after coverage ends, regardless of when treatment began.

32. Chelation therapy, except for the treatment of acute arsenic, gold, mercury or lead poisoning.

33. Any expense or charge for services or supplies that are provided or paid for by the federal government or its agencies, except for:
   - The Veterans’ Administration, when services are provided to a veteran for a disability that is not service-connected;
   - A military hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services; or
   - A group health plan established by a government for its own civilian employees and their dependents.

34. Any loss, expense or charge that is incurred while the participant is on active duty or training in the armed services, National Guard, or reserves of any state or country and for which any governmental body or its agencies are liable.

35. With respect to organ transplants, the Plan will not cover transplants deemed experimental or investigative by standard medical guidelines, nor will it cover:
   - Any transplant expense when approved alternative remedies are available;
   - Any animal organ or mechanical equipment, devices or organ(s), except as specifically noted;
   - Anything that is otherwise excluded under the Plan’s limitations; and
   - Any expenses incurred by a donor associated with a body organ transplant if the recipient is not covered under this Plan.

36. Any expense related to court-ordered or any random drug testing, unless part of medical care.
Prescription Drug Program

When your physician prescribes a prescription drug, you have several options. Your share of the cost of prescription drugs depends on where you buy your drug, what type of drug you are buying, and whether you have the Basic Benefits or Supplemental Benefits Plan coverage.

### Basic Benefits Prescription Drug Program Chart

<table>
<thead>
<tr>
<th>Basic Benefits Prescription Program: (These benefits apply only if you are covered under the Basic Eligibility Rule)</th>
<th>Retail Program: for a 30-day supply for immediate drug needs or short-term medications, maintenance drugs or supplies are subject to a stepped co-pay; co-pay will be doubled after 2 fills for maintenance drugs when not purchased through CVS retail stores or CVS/Caremark Mail Service</th>
<th>Mail Service Program: for a 90-day supply for maintenance or long-term medications</th>
<th>Maintenance Choice Program at CVS Pharmacies: for maintenance or long-term medications purchased at CVS pharmacies for 90-day supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>When your prescription falls into this category:</td>
<td>And you buy it from a participating retail network pharmacy, you pay:</td>
<td>And you buy it from the mail service program, you pay:</td>
<td>And you buy it from a CVS retail pharmacy, you pay:</td>
</tr>
<tr>
<td>Tier 1: Generic drug</td>
<td>$10 co-pay for 30-day supply</td>
<td>$20 co-pay for 90-day supply</td>
<td>$20 co-pay for 90-day supply</td>
</tr>
<tr>
<td>Tier 2: Brand-name drug on formulary*</td>
<td>$20 co-pay for 30-day supply</td>
<td>$40 co-pay for 90-day supply</td>
<td>$40 co-pay for 90-day supply</td>
</tr>
<tr>
<td>Tier 3: Brand-name drug not on formulary</td>
<td>$40 co-pay for 30-day supply</td>
<td>$80 co-pay for 90-day supply</td>
<td>$80 co-pay for 90-day supply</td>
</tr>
</tbody>
</table>

*In order to be considered a Tier 2 drug, the drug must be listed on the Caremark formulary (preferred drug list). The formulary is a list of preferred prescription medications that have been chosen because of clinical effectiveness, cost and safety. The Caremark formulary changes often to reflect the most current developments. If you would like a copy of the most up-to-date version of the formulary to take with you to a doctor’s appointment, call Caremark at 1-866-273-8408, or go to [www.caremark.com](http://www.caremark.com).
Supplemental Benefits Prescription Drug Program Chart

**Supplemental Benefits Prescription Program**  
(These benefits apply only if you are covered under the Supplemental Eligibility Rule)

| Retail Program: for a 30-day supply for immediate drug needs or short-term medications, maintenance drugs or supplies are subject to a stepped co-pay; co-pay will be doubled after 2 fills for maintenance drugs when not purchased through CVS retail stores or CVS/Caremark Mail Service | Mail Service Program: for a 90-day supply for maintenance or long-term medications | Maintenance Choice Program at CVS Pharmacies: for a 90-day supply: for maintenance or long-term medications purchased at CVS pharmacies |

Subject to $250 individual/$500 family annual prescription deductible (RxD)

<table>
<thead>
<tr>
<th>When your prescription falls into this category:</th>
<th>And you buy it from a participating retail network pharmacy, you pay:</th>
<th>And you buy it from the mail service program, you pay:</th>
<th>And you buy it from a CVS retail pharmacy, you pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: Generic drug</td>
<td>$20 co-pay for 90-day supply, after you pay your RxD</td>
<td>$40 co-pay for 90-day supply, after you pay your RxD</td>
<td>$40 co-pay for 90-day supply, after you pay your RxD</td>
</tr>
<tr>
<td>Tier 2: Brand-name drug on formulary*</td>
<td>$40 co-pay for 90-day supply, after you pay your RxD</td>
<td>$80 co-pay for 90-day supply, after you pay your RxD</td>
<td>$80 co-pay for 90-day supply, after you pay your RxD</td>
</tr>
<tr>
<td>Tier 3: Brand-name drug not on formulary</td>
<td>$80 co-pay for 90-day supply, after you pay your RxD</td>
<td>$160 co-pay for 90-day supply, after you pay your RxD</td>
<td>$160 co-pay for 90-day supply, after you pay your RxD</td>
</tr>
</tbody>
</table>

*In order to be considered a Tier 2 drug, the drug must be listed on the Caremark formulary (preferred drug list). The formulary is a list of preferred prescription medications that have been chosen because of clinical effectiveness, cost and safety. The Caremark formulary changes often to reflect the most current developments. If you would like a copy of the most up-to-date version of the formulary to take with you to a doctor’s appointment, call Caremark at 1-866-273-8408, or go to [www.caremark.com](http://www.caremark.com).

Making Sense of Rx Levels

- Tier 1: This is the lowest co-pay and applies to most generic drugs.
- Tier 2: This is the mid-level co-pay and applies to brand-name drugs on the formulary list (preferred drugs).
- Tier 3: This is the highest co-pay and applies to brand-name drugs that are not on the formulary list (non-preferred drugs). Most Tier 3 drugs have an approved generic equivalent covered at Tier 1 or an alternative brand-name drug covered at Tier 2.

Some drugs or items listed on the formulary may not be covered at all under this Plan. In this case, you are eligible to purchase these through a special mail service or maintenance choice arrangement where you will receive the CVS/Caremark discount for these drugs or supplies. For example, weight loss drugs or drugs for cosmetic or infertility purposes are not covered, but you can pay 100% of the discounted rate. For a list of participating pharmacies in your area, or to ask if your drug is on the Plan’s formulary, call Caremark Customer Care at 1-866-273-8408, or go to [www.caremark.com](http://www.caremark.com).

If you need help in determining what tier your prescription falls into, call Caremark at 1-866-273-8408 for 24-hour assistance.
Stepped co-pay – The first two fills of a maintenance drug or supply are covered at the standard co-pay if purchased at any retail store. After two fills you will be charged two times the retail pharmacy co-pay for any additional fills of the same maintenance drug or supply purchased at a retail store unless you purchase a 90-day supply at a CVS retail store. If your prescription costs less than the co-pay you will pay the full cost of the drug at the CVS/Caremark discounted rate. To avoid the stepped co-pay you should purchase maintenance drugs or supplies at 90-day rates through either CVS/Caremark Mail Service or at CVS/Caremark retail stores.

Maintenance Drugs or Supplies – A maintenance drug or supply is one that is considered long term. Examples include blood pressure pills, diabetic or cardiac medications, birth control pills, or diabetic test strips. Maintenance drugs should be purchased at 90-day rates at CVS/Caremark Mail Service or CVS retail stores to avoid a stepped co-pay.

Diabetic Meter Program – Participants can receive a free blood glucose meter kit if they have diabetes or are required to test their blood sugar levels by their doctor. Call the CVS/Caremark Diabetic Meter Team at 1-800-588-4456 weekdays between 6:00 a.m. and 4:00 p.m. Mountain Time. Meters are provided by Roche (ACCU-CHEK) and LifeScan (ONE TOUCH). You may receive one meter kit as part of your pharmacy benefit every three years.

Smoking Cessation Drugs – The Plan includes coverage for prescription drugs for smoking cessation such as Chantix and Zyban. These prescriptions are available at no co-pay cost to you for up to six months each year. If you need additional medication and have a prescription from your doctor, you can purchase additional medication using the CVS/Caremark discount, but you will pay the full cost of the prescription.

Rx Savings Plus – Participants also have access to an optional prescription discount plan for non-covered drugs including pet medications when your pet uses a prescription that is also used to treat a human condition. You can save an average of 20% off the regular retail price and up to 50% on select medications when you order these medications through CVS/Caremark Mail Service. Call 1-877-673-3688 toll-free, or visit www.rxsavingsplus.com to locate a participating retail pharmacy or obtain a price estimate for your prescription.

CVS/Caremark ExtraCare Health Card – Your CVS/Caremark prescription drug benefit includes access to a special ExtraCare Health Card that enables you to receive a 20% discount on regularly priced CVS/pharmacy brand, FSA-eligible, health-related items of $1 or more in stores or online. Your ExtraCare Health Card also provides you with other benefits including:
- $1 in ExtraBucks Rewards for every two prescriptions filled at CVS/pharmacy
- 2% back in ExtraBucks Rewards on all your purchases made in the store and online at CVS.com
- Instant savings on items featured in the weekly advertising circular

You can contact CVS/Caremark at 1-888-543-5938 to order new key tags or register cards.

How to Use the Prescription Drug Program
To make the most of the prescription drug program, buy your prescription from a participating pharmacy. Or, if your physician prescribes maintenance medications, use the mail service program or CVS/Caremark retail stores.

To Fill Your Prescription at a Participating Retail Network Pharmacy
- Present your CVS/Caremark ID card to the pharmacist along with your prescription.
- Pay the co-pay that applies to your prescription. Pharmacists at participating pharmacies have instant online access to the Plan formulary.
- Sign the claim sheet that your pharmacist provides.

To Fill Your Prescription at a Non-Participating Pharmacy
- You must pay the full cost of the prescription when you fill it.
- Call CVS/Caremark Customer Care at 1-866-273-8408 to request a claim form.
- Mail your completed claim form along with your receipt to CVS/Caremark at the address shown on the form.
- CVS/Caremark will reimburse you for the cost of your prescription up to the negotiated amount they would have paid at a network pharmacy, less the applicable co-pay.
Save Money – Use Mail Service or CVS/Caremark Retail Stores

Mail Service: Use the mail service program for long-term maintenance drugs. Plan ahead—home delivery can take up to 14 days. You save a one-month co-pay with mail service purchases.

CVS/Caremark Retail Stores: You can use these stores for maintenance drugs and save the one-month co-pay on 90-day prescriptions as if they are being filled by mail service.

Retail: Buy your prescriptions for urgent or emergency care at your local participating pharmacy.

If you need a prescription immediately, or if you are running out of a maintenance medication that you usually order by mail and there isn’t enough time to order a refill, get your drug refilled locally at a retail location while you wait for your regular mail-order prescription to arrive.

To Fill Your Prescription Through the Mail Service Program

- Ask your physician to prescribe up to a 90-day supply of your maintenance medication(s).
- The first time you use mail order for each prescription, be sure to request two prescriptions: one for a 30-day supply that you can fill at a local participating pharmacy, and one for a 90-day supply that you can order by mail.
- Use the mail service claim form in your CVS/Caremark handbook, print it from the Fund’s website at www.local4funds.org or call CVS/Caremark for a new form.
- Mail the completed form and prescription(s) with credit card information or a personal check for your co-pay and/or deductible, if applicable, to the address shown on the form.
- To order refills, use the return envelope you receive back with your prescription, or call CVS/Caremark at 1-866-273-8408 to re-order by phone. Or re-order online at www.caremark.com.
- You can also set up your prescription so that CVS/Caremark will automatically re-order for you and contact your doctor when the prescription is about to expire.
- If you choose to re-order yourself, re-order your prescription three weeks in advance of the date your current prescription runs out. Suggested refill dates will be included on the prescription label you receive from CVS Caremark.
- If you have questions about the refill process, you can call CVS/Caremark for 24-hour assistance.

Purchase Non-Covered Drugs at a Discount

Drugs that are not covered under the Plan can be purchased at 100% of the CVS/Caremark discounted rate if you order non-covered drugs through the CVS/Caremark Mail Service program or at CVS/Caremark retail stores. If you are not sure about the coverage status of your mail-order purchase, call CVS/Caremark Customer Care at 1-866-273-8408 before placing your order. CVS/Caremark will run a test claim to estimate your cost. If you order non-covered drugs through mail service, you will be charged 100% of the discounted rate and such drug purchases are not refundable. You also may want to compare the CVS/Caremark discount with the discount available from your local pharmacy.

Drugs That Require Preauthorization

You or your physician must contact CVS/Caremark to initiate preauthorization if your physician prescribes:
- Antifungal medications such as Lamisil tablets;
- Nexium;
- Non-sedating antihistamines;
- Obesity medications (covered only if the patient meets criteria for gastric bypass surgery);
- Retin A for adults (covered only if the patient meets acne criteria);
- Buprenorphine and naloxone sublingual tablets for treatment of substance use disorder;
- Naltrexone for treatment of alcohol addiction; and
- Other drugs, as the Plan deems necessary.
To request preauthorization, your physician must complete the Caremark prior authorization form. If you fail to request preauthorization for any of these drugs, the Plan will not cover them and you will be responsible for paying the full cost of the drugs.

### What the Prescription Drug Program Does Not Cover

The Prescription Drug Program does not cover:

- Non-federal legend drugs, other than insulin. A legend drug must bear the following phrase on its packaging: “Caution: (USA) federal law prohibits dispensing without a prescription”;
- Therapeutic devices or appliances, support garments, and other non-medical substances;
- Drugs labeled “Caution—limited by federal law to investigational use,” or experimental drugs, including compounded medications for non-FDA-approved use;
- 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 you;
- Medication to be taken by or administered to you, in whole or in part, while you are a patient in a licensed hospital, rest home, sanatorium, extended care facility, skilled nursing facility, nursing home, or similar institution that operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals (the Medical Plan, rather than the Prescription Drug Program, covers prescription drugs in these cases);
- Any prescription refilled in excess of the number of refills specified by your physician or any refill dispensed after one year from the physician’s original order;
- Fertility medications; and
- Erectile dysfunction medications.

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**Caremark Specialty Pharmacy**

Caremark provides 24-hour access to specialty pharmacy service and will coordinate the delivery of specialty medications to your home. Call 1-800-237-2767 or visit [www.caremark.com](http://www.caremark.com) to verify your coverage of medications for:

- Blood modifiers;
- Gaucher’s disease;
- Growth hormone disorders;
- Hemophilia, Von Willebrand disease and related bleeding disorders;
- Hepatitis C;
- Immune deficiencies;
- Multiple sclerosis;
- Cancer;
- Osteo/rheumatoid arthritis;
- Pulmonary hypertension; and
- Respiratory syncytial virus (RSV).

Caremark provides pharmacist-led clinical services including education and calls to offer counseling, assistance in coordinating injection training, and access to emergency pharmacist consultation, 24 hours a day, 365 days a year.
SECTION III: Dental, Vision and Hearing Coverage

Dental Plan

The Dental Plan assists you and your family in paying dental expenses if you are covered under the Basic Benefits Plan. These services are administered by Delta Dental of Massachusetts. Supplemental Benefits Plan participants do not have dental coverage unless they purchase the additional benefits available through the Bridge Plan. The Dental Plan utilizes the Delta Dental PPO and Delta Dental Premier Network of dentists.

What the Dental Plan Covers

All covered dental services are paid as follows:

<table>
<thead>
<tr>
<th>Dental Plan Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum calendar-year benefit per covered person (not including orthodontia) age 19 and over</td>
</tr>
<tr>
<td>No annual maximum applies to covered persons under age 19</td>
</tr>
<tr>
<td>Deductible</td>
</tr>
<tr>
<td>Covered services (except orthodontia)</td>
</tr>
<tr>
<td>Type 1 Diagnostic and Preventive</td>
</tr>
<tr>
<td>Type 2 Restorative and Other Basic</td>
</tr>
<tr>
<td>Type 3 Major Restorative</td>
</tr>
</tbody>
</table>

Orthodontia (for covered dependents up to age 19)

Your cost is 50% of charges, up to a separate lifetime maximum benefit of $2,000 per covered dependent, for non-medically necessary orthodontia. Charges above $2,000 in benefits are your responsibility, unless the orthodontia is medically necessary, as determined by the Plan.
Delta Dental PPO Dentists – These dentists have agreed to accept a lower negotiated fee for their services. This helps reduce your coinsurance. Your routine diagnostic and preventive services are covered at 100% when you use a Delta Dental PPO dentist. To locate a Delta Dental PPO dentist, visit the Delta Dental website at [www.deltadentalma.com](http://www.deltadentalma.com) or call Delta Dental at 1-800-872-0500.

Delta Premier Dentists – These dentists also discount their charges with Delta Dental, helping to reduce your coinsurance, but diagnostic and preventive services are not covered at 100%. To locate a Delta Dental Premier dentist, visit the Delta Dental website at [www.deltadentalma.com](http://www.deltadentalma.com) or call Delta Dental at 1-800-872-0500.

Out-of-Network Dentists – These dentists do not have a contract with Delta Dental. Delta Dental reimburses you for services with these dentists using the lesser of the dentist’s actual charge or the maximum plan allowance for non-participating dentists.

Dental Surgery
Oral surgeons and periodontists generally perform dental surgery in their dental offices or at a hospital outpatient surgical day unit. There are times when such a procedure requires inpatient hospitalization.

Professional dental surgery charges (surgeon’s fees), whether you incur them in a dental office or in a hospital surgical day care setting, are covered under the Dental Plan. Inpatient or outpatient hospital facility charges incurred in connection with dental surgery are paid under the Dental Plan, but use of a facility is subject to prior authorization by Blue Cross Blue Shield. Use of an emergency room for dental services is not covered under the Medical or Dental Plan unless the services are related to an accidental injury not related to chewing.

Pre-Treatment Estimates
You are not required to have a pre-treatment estimate, but you may choose to have your dentist request a pre-treatment estimate through Delta Dental for more expensive procedures. This ensures that you know in advance how much the Plan will pay and what your share of the expenses will be.

Covered Expenses
Here is an overview of Dental Plan benefits.

**Preventive, Diagnostic and Emergency Services (Type 1)**

- **Preventive procedures** prevent or minimize the occurrence of dental disease. Covered preventive procedures include: prophylaxis (cleaning and polishing of teeth), twice per calendar year; fluoride applications for children (up to age 19), twice per calendar year; sealants on unrestored permanent molars for covered dependents through age 15, once per tooth; and space maintainers required due to premature loss of teeth for children under age 14 and not for the replacement of primary or permanent anterior teeth.
- **Diagnostic procedures** assist in the evaluation and identification of existing dental conditions and the dental care required. Covered diagnostic services include comprehensive oral examination (including the initial dental history and charting of teeth), once every 60 months; periodic oral evaluation, twice per calendar year; bitewing X-rays, twice per calendar year; bitewing or single-tooth X-rays, as conditions indicate; full-mouth X-rays, once every 60 months.
- **Periodontal maintenance** once every three (3) months following active periodontal treatment. Not to exceed two (2) in one calendar year if combined with preventive cleanings.

**Basic Restorative Services (Type 2)**

- **Basic restorations** include those pertaining specifically to the repair and reconstruction of natural teeth. Covered services include amalgam (silver) fillings or synthetic tooth color fillings (not on back teeth), once every 24 months per surface per tooth. Synthetic (white) fillings are limited to single-surface restorations for posterior teeth. Multi-surface synthetic restorations on posterior teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. You are responsible up to the dentist’s charge. No benefits are provided for replacing a filling within 24 months of the date that the prior filling was furnished.
- **Sedative filling**, once per tooth; stainless steel crowns on baby teeth, once every 24 months per tooth.
- **Oral surgery** includes procedures such as simple/surgical tooth removal, removal of impacted teeth and other oral surgical procedures. It also includes alveoplasty once per quadrant per lifetime.
- **General anesthesia** when necessary and appropriate for covered surgical services, only when provided by a licensed, practicing dentist.
• **Emergency** services provide treatment to relieve dental pain. Covered emergency services include oral evaluation problem focused exams twice per calendar year.

• **Endodontics** (root and pulp care) is the specialty that deals with procedures for the treatment of diseases of the pulp chamber and pulp canals (root canal filling) of permanent teeth, including the treatment of the nerve of the tooth, the removal of dental pulp and pulpal therapy. Root canal treatment is once per lifetime per tooth. Vital pulpotomy is limited to deciduous teeth.

• **Periodontics** (gum and bone care) includes the examination, diagnosis and treatment of diseases of the gums. Covered services include periodontal surgery, scalings and/or root planing, management of acute infections and lesions of the mouth and the removal or reshaping of diseased bone (osseous surgery), crown lengthening and bone grafts.

• **Repair** of fixed bridgework; repair or relining of partial or full dentures; repair or recementing of crowns, onlays and bridgework; and adding teeth to existing partial or full dentures are included in this category.

**Major Restorative Services (Type 3)**

• **Major restorations** are more complex than basic restorations. Covered services include crowns (caps), inlays and onlays — used when teeth cannot be restored with regular fillings due to severe decay or fractures, once each 60 months per tooth.

• **Prosthodontics** (teeth replacement), or procedures for the construction, placement, insertion and repair of natural teeth. This category includes fixed bridgework, partial and removable dentures once each 60 months, and dental implants in lieu of bridges and individual implants as needed. Bone grafting to support an implant is also covered here.

• **Temporary partial dentures** to replace any of the six upper or lower front teeth, but only if they are installed immediately following the loss of teeth during the period of healing or for the replacement of permanent teeth for covered individuals who are under 16 years.

**Orthodontic Services (limited to eligible dependent children under age 19)**

Orthodontic treatment provides for the proper alignment of the teeth. Covered services include straightening of crooked, crowded or protruding teeth.

**Rollover Max**

Although the Plan’s calendar year maximum is $2,500, up to $700 in unused benefits can be rolled over to a subsequent year, to a maximum of $1,500 per lifetime for rollover purposes. In order to be eligible for this benefit you must have received an annual oral exam or cleaning in the prior calendar year and used less than $900 in benefits that year.

**What the Dental Plan Does Not Cover**

The Dental Plan does not cover:

• Treatment of teeth or gums for cosmetic purposes (including charges for whitening, bleaching agents, or personalization or characterization of dentures);

• Treatment of an injury or dental disease for which coverage would be provided by Workers’ Compensation, regardless of whether such coverage was in force or whether you applied for such coverage or received Workers’ Compensation benefits;

• War-related diseases or injuries or losses incurred while engaged in military, naval or air service so long as coverage is provided by the military;

• Replacement of prostheses which cannot be made serviceable less than five years after a preceding placement;

• Charges for which you or your covered family members are not required to pay, including charges for services furnished by any hospital or organization which normally makes no charge if the patient has no hospital, surgical, medical or dental insurance;

• Charges for any dental procedures that are included as covered medical expenses under the Medical Plan;

• Charges for treatment by anyone other than a dentist, except for scaling or cleaning of teeth, which may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and direction of the dentist;

• Rebase or reline of a denture more often than once in any three-year period;

• Replacement of lost or stolen dentures, bridges, space maintainers or periodontic appliances;

• Charges for periodontal splinting or myofunctional therapy;

• Appliances or restorations (not in conjunction with the orthodontic benefit) to:
  – Increase vertical dimension;
  – Restore occlusion;
  – Replace tooth structure lost by attrition;
– Correct congenital or developmental malformations; or
– Improve aesthetic appearance;

- Any expense or charge for treatment of craniomandibular or temporomandibular joint (TMJ) disorders (this treatment is covered as a medical expense, with limits, under the Medical Plan); and
- Services that are not generally accepted as determined by Delta Dental, services that are not described as a benefit in this Summary Plan Description, services rendered due to the requirements of a third party, fees for travel time, a method of treatment more costly than is customarily provided, fees for appointments you fail to keep, fees for dietary advice and instructions in dental hygiene, and consultations.

Vision Plan

The Vision Plan covers certain vision care expenses for you and your family. Davis Vision administers vision benefits for the Plan. Participants enrolled under the Basic Benefits Plan or those who have purchased Bridge Coverage or COBRA 2 or the Pension 50% Buy-In Plans are eligible for Vision Plan benefits. Participants enrolled under the Supplemental Benefits Plan, Pension 100% Buy-In, COBRA 1, COBRA 3 or COBRA 4 Plans have no Vision Plan benefits.

Levels of Coverage

When you receive care from a panel provider: Davis Vision maintains a network of panel providers who offer services and supplies at negotiated fees. When you purchase Plan items from a panel provider, your out-of-pocket costs are limited. When you purchase non-Plan items from a panel provider, you must pay the provider the difference between the Plan allowance and the actual cost of the items. You need not file any claim forms. The panel provider will inform you of the cost at the time of service.

When you receive care from a non-panel provider: You pay more for care and services, depending upon where you receive your care and what you purchase. With non-panel providers, you must pay the provider directly at the time of service and then submit your completed claim form to Davis Vision, along with your receipt, for reimbursement up to the Plan allowance.

How to Use the Vision Plan

To use the Vision Plan, follow these steps:

- If you choose a panel provider, the provider will handle all paperwork and approvals.
- If you make an appointment with a non-panel provider, call Davis Vision to request a claim form. Ask the provider to complete the bottom portion of the form.
- After you sign the claim form, send it together with your paid receipt to the address shown on the claim form.
- Davis Vision will send a check to your home address reimbursing you up to the Plan’s allowable expense.

Identification When You Use the Vision Plan

When you use your Davis Vision benefits, do not use your Blue Cross Blue Shield ID number. All Davis Vision account information is maintained under the Social Security number of the covered participant.

For a list of Davis Vision providers call Davis Vision at 1-800-999-5431 to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the Davis Vision network providers nearest you, or access the website at www.davisvision.com and utilize the “Find a Doctor” feature. Or you can call the Funds Office. Blue Cross Blue Shield network Medical Plan providers are not considered panel providers for purposes of the routine vision benefit provided through Davis Vision.

What the Vision Plan Covers

Covered vision care expenses include eye examinations and eyeglasses or contact lenses. Eligible expenses are covered according to the following schedule.

<table>
<thead>
<tr>
<th>Vision care</th>
<th>For you, your spouse and your covered dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exam</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>One pair of eyeglasses or contact lenses</td>
<td>Once every 12 months</td>
</tr>
</tbody>
</table>
You can check your eligibility for vision services by calling 1-800-999-5431 or by going to [www.davisvision.com](http://www.davisvision.com).

Your share of the cost depends on where you receive care. Here are the services the Plan covers.

<table>
<thead>
<tr>
<th>When you receive this care:</th>
<th>From a panel provider and buy these Plan items, you pay:</th>
<th>From a panel provider and buy non-Plan items, you pay:</th>
<th>From a non-panel provider, you pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive eye examination</td>
<td>Nothing-paid in full</td>
<td>Not applicable</td>
<td>Amounts above $30</td>
</tr>
<tr>
<td>Frames</td>
<td>Nothing-paid in full</td>
<td>Amounts above $14</td>
<td>Amounts above $25</td>
</tr>
<tr>
<td>Contact lens fitting</td>
<td>Nothing-paid in full</td>
<td>The full cost</td>
<td>The full cost</td>
</tr>
<tr>
<td>Single, bifocal or trifocal lenses</td>
<td>Nothing-paid in full</td>
<td>Nothing-paid in full</td>
<td>Single-vision lenses: Amounts above $20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bifocal lenses: Amounts above $30</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Trifocal lenses: Amounts above $40</td>
</tr>
<tr>
<td>Invisible bifocal lenses (progressives)</td>
<td>Standard and premium-paid in full</td>
<td>Standard and premium-paid in full</td>
<td>The full cost</td>
</tr>
<tr>
<td>Ultra: $50</td>
<td>Ultra: $50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposable/planned replacement lenses</td>
<td>$35 co-pay</td>
<td>Amounts above $45</td>
<td>Medically necessary with pre-approval: Amounts above $200</td>
</tr>
<tr>
<td>Disposable contact lenses: Four boxes/multi-packs</td>
<td></td>
<td>Members may use their $45 credit to go toward the providers own supply of contact lenses, evaluation, fitting and follow-up care. This would also apply towards all contact lenses received at participating retail locations.</td>
<td>Elective: Amounts above $100</td>
</tr>
<tr>
<td>Planned replacement: Two boxes/multi-packs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Safety eyewear

You may choose to buy safety eyewear as an alternative to regular dress eyewear, and the co-pays and coverage amounts will vary depending on what you purchase and where.
Generally, your eyeglasses will be sent to your provider from the laboratory within two to five business days after your order is placed. More delivery time may be needed when you select out-of-stock frames, glare resistant treatment, specialized prescriptions or non-“Tower Collection” frames.

The following services also are covered in full when you use a panel provider:
- Oversized lenses;
- Fashion tinning of plastic lenses;
- Gradient tints;
- Grey #3 prescription sunglasses (glass lenses);
- SuperShield* (scratch-protective) coating;
- Photogrey Extra* (sun-sensitive) glass lenses;
- Blended invisible bifocals;
- Progressive addition multi-focal lenses (conventional bifocals are covered for anyone who cannot adapt to progressive lenses);
- Polycarbonate lenses; and
- Post-cataract lenses.

Optional lens types or coatings available: You can pay a discounted fixed fee for additional optional items:
- $12 for UV (ultraviolet) protective coating
- $33 for Transitions® (sun-sensitive) plastic lenses
- Anti-reflective Coating – $18 - standard – $24 - premium – $30 - ultra
- $75 for Polarized lenses
- $55 for high-index (thinner, lighter) lenses
- $50 for ultra progressive lens type

A mail-order replacement contact lens service, Lens 1-2-3®, also provides a fast and convenient way to purchase replacement contact lenses at significant savings. Call 1-800-536-7123 for more information, or visit the Lens 1-2-3 website at www.lens123.com.

Laser Vision Surgery

Although the Plan does not cover laser vision surgery, special discounts are available through the Plan’s affiliation with Davis Vision when you receive care from eye surgeons in the Davis Vision Laser network. Eligible participants may receive a discount of up to 25% off providers’ usual and customary fee or a minimum 5% off any advertised special for either PRK or conventional LASIK laser vision correction from the laser vision correction network. Alternatively, some facilities may offer a flat rate which equates to these comparable discount levels. Providers offering Flying Spot (or other emerging technologies of laser vision correction) may be available at similar discounts; however, the usual and customary fee may be higher than PRK or conventional LASIK laser vision correction.

Participants are responsible for paying all fees directly to the provider or facility. Davis does not assume any financial responsibility to the participant for access to these discounts. Davis will not reimburse a participant if a participant is dissatisfied with the discount obtained; therefore participants should determine the level of discount available and its acceptability prior to receiving services.

To access this discount program, participants will use the enrollee’s Social Security number to access the Davis Vision website or Interactive Voice Response (IVR) Unit to obtain a confirmation. Once the website or IVR is accessed, participants can follow the prompted steps to obtain confirmation.

For more information, visit www.davisvision.com or call Davis Vision at 1-800-999-5431. The Medical Plan does not cover any complications arising from this non-covered service.

Davis Vision Value Advantage Discount Program

The Davis Vision Value Advantage Discount Program is available for the following participants who do not have Vision Care Services: retirees in the pension buy-in program, uninsured retirees, COBRA participants and participants in the Supplemental Plan. It is also available for insured participants who wish to purchase additional eyewear.
**Value Advantage Program Costs (to purchase additional vision services after exhausting vision benefits)**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exam only</td>
<td>$54</td>
</tr>
<tr>
<td>Materials only</td>
<td>$131</td>
</tr>
<tr>
<td>Eye exam and materials</td>
<td>$185</td>
</tr>
</tbody>
</table>

You may purchase additional discounted eyewear through the Davis Vision Value Advantage Program, available at Davis Vision panel providers. To take advantage of this program and pre-purchase services, call 1-800-999-5431. A Davis Vision service representative will discuss payment options with you.

**What the Vision Plan Does Not Cover**

The Vision Plan does not cover:

- Benefits for the medical treatment of eye disease or injury (these services are covered under the Medical Plan);
- Non-routine eye examinations and non-prescription eyewear;
- Vision therapy;
- Special lens designs or coatings not listed in this section;
- Replacement of lost eyewear;
- Non-prescription (plano) lenses;
- Services not performed by licensed personnel;
- Contact lenses and eyeglasses during a single benefit cycle; or
- Two pairs of eyeglasses in lieu of bifocals.

A one-year warranty (from the date of service) applies to all Plan frames and lenses. The warranty applies to any Plan eyeglasses that are broken in normal use and returned to the office from which they were dispensed. The warranty does not apply to non-Plan glasses or to glasses received from a non-panel provider.

If you lose your medical coverage and meet certain conditions, you and your eligible dependents may be able to continue coverage through COBRA for up to 18 or 36 months by paying 102% of the full cost of the group plan.

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**Hearing Plan**

The Hearing Plan covers routine hearing-related expenses for covered employees under the Basic Benefits Plan. If you are enrolled under the Supplemental Benefits Plan, you are not covered under the Hearing Plan. Benefits are limited to services you receive from providers affiliated with EPIC Hearing Healthcare.

**What the Hearing Plan Covers**

<table>
<thead>
<tr>
<th>When you receive the following hearing-related services from an EPIC Hearing Healthcare provider:</th>
<th>The Plan pays the following amount for covered employees, Spouses or Dependents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>100%</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>$1,300 per ear, every four years</td>
</tr>
</tbody>
</table>

Hearing Plan benefits are available for all insured family members.

**What the Hearing Plan Does Not Cover**

The Hearing Plan does not cover:

- Hearing aid batteries (unless provided at no cost by EPIC Hearing Healthcare); or
- Services provided by a provider who does not participate in the EPIC Hearing Healthcare Plan network.

For information on participating providers and to receive a referral to a network provider, contact EPIC Hearing Healthcare at 1-866-956-5400. For more information visit the website at [www.epichearing.com](http://www.epichearing.com).
SECTION IV: Life and Disability Insurance

Disability – Weekly Accident and Sickness Benefits (Loss of Time)

If you are the covered employee and unable to work because of a non-work-related disabling illness or injury (including pregnancy), you may receive weekly accident and sickness benefits. Weekly accident and sickness benefits provide you with a continuing source of income while you are disabled.

You are only eligible for these benefits if you are a covered employee enrolled in the Basic Benefits Plan. If you are enrolled under the Supplemental Benefits Plan, you are not eligible unless you have purchased the Bridge Plan. Pregnancy-related disability is based on “medical necessity” as documented by your physician.

Covered Benefits

If you are approved to receive weekly accident and sickness benefits, you will receive $400 per week for up to 26 weeks of your continuous disability. As required by law, Social Security and Medicare taxes are withheld from these payments. You may elect to have federal income taxes withheld.

You will be considered totally disabled if, as the result of an illness or accidental injury, you are unable to engage in any work for pay for which you are suited by education, training or experience. You must not be performing any work of any kind for wage or profit, and you must be under the care of a medical physician or surgeon.

The opinion of a chiropractor as to the extent and duration of your total disability is not acceptable for the payment of this lost time benefit, unless the chiropractor’s diagnosis and prognosis are verified in writing by a medical physician who is licensed by the American Medical Association and the state within which the physician practices medicine.

When Benefits Are Payable

Depending on the nature of your disability, you may have to satisfy a waiting period before weekly accident and sickness benefits are payable, as shown in the following chart. You receive no payments from the Plan during the waiting period.

<table>
<thead>
<tr>
<th>Type of disability</th>
<th>Benefits begin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental injury</td>
<td>Immediately</td>
</tr>
<tr>
<td>Anything other than accidental injury (e.g., sickness/pregnancy)</td>
<td>After seven calendar days</td>
</tr>
</tbody>
</table>

If You Become Disabled Again

Successive periods of the same disability separated by fewer than 10 days of full-time, active work are considered one continuous period of disability. If, after returning to work, you become disabled due to an illness or injury that is totally unrelated to your previous disability, it will be treated as a new period of disability.

What the Weekly Accident and Sickness Plan Does Not Cover

Weekly accident and sickness benefits do not cover:

- Absence due to an illness or injury for which you are not under the care of a medical physician or surgeon;
- Job-related accidents or illnesses for which you are entitled to Workers’ Compensation benefits, regardless of whether you apply for or receive those benefits;
- Absences during which you receive pension benefits from the Plan’s Pension Fund;
- Combat, war or any act of war, whether declared or undeclared;
- Service in the military of a foreign country or as a mercenary;
• Illness or injury resulting from your commission of a felony unless the injuries are the result of a medical condition, or unless you are the victim of the commission of a felony or an attempt to commit a felony or the victim of domestic violence;
• Intentionally self-inflicted injury or attempted suicide, whether you are sane or insane;
• Flight travel, unless injury occurs as a fare-paying passenger on a regularly scheduled airline;
• Injuries resulting from bungee jumping or from participating in an organized racing event involving motorized vehicles, such as snowmobile, motorcycle or all-terrain vehicle races; or
• Parachuting, sky-diving or scuba diving.

Life Insurance Plan – AIG Life Insurance Company (AIG)

The Plan pays as a life insurance benefit the amount of life insurance in force for you if you die while you are an insured, eligible covered employee under the Plan. You name your beneficiary. AIG underwrites the Life Insurance Plan.

Covered employees enrolled under the Basic Benefits Plan are eligible for life insurance benefits. If you are married and your Spouse dies, you would be eligible for life insurance benefits.

Covered employees enrolled under the Supplemental Benefits Plan are not eligible for life insurance benefits unless they have purchased the Bridge Plan.

Covered Benefits

The life insurance benefit amount is $50,000 if you die. Upon your death, AIG pays the proceeds of your life insurance as a lump sum to your designated beneficiary.

Your life insurance benefit is reduced to $32,500 when you reach age 70 and you are still an active employee; it is further reduced to $25,000 when you reach age 75 as an active employee.

If your Spouse dies, the life insurance benefit amount is $2,000, providing you are married on the date of death.

Naming Your Beneficiary

You may select any beneficiary you wish, including your estate, by completing and returning an enrollment card to the Funds Office. Provided you are not restricted from changing your beneficiary in accordance with a separation agreement or divorce decree, you may change your beneficiary at any time by completing and returning a new enrollment card to the Funds Office.

If you do not name a beneficiary, or if no beneficiary survives you, benefits will be distributed in equal shares in the following order to your:
• Surviving legal spouse;
• Surviving natural and/or adopted children;
• Surviving parent(s); or
• Estate.

If you name a minor child as your designated beneficiary, you should be aware that death benefits are not payable until the child reaches age 18 unless a legal guardian has been appointed to accept the death benefits on the child’s behalf.

Extension of Life Insurance (Waiver of Premium) – AIG Life Insurance Company (AIG)

If you are not able to work due to disease or injury, your life insurance (but not accidental death and personal loss coverage) may be extended if AIG determines you are permanently and totally disabled.

If you become totally disabled before reaching age 60, your life insurance under this policy will continue for one year from the date you became totally disabled, provided that you remain totally disabled and premiums are paid when due. The life insurance benefit will be the same amount, subject to any applicable benefit reduction. Insurance may be continued beyond such one-year period, provided:
• You furnish proof satisfactory to AIG, at least six months from the date such total disability began, that you have been totally disabled continuously from the date the total disability began; and
• Such proof is furnished to AIG no later than one year after the date the total disability begins.
Upon submission of the required proof, premiums paid on your behalf during the totally disability will be refunded. AIG will waive the required premium payments until you are no longer totally disabled, provided that you (a) furnish proof that the totally disability has continued uninterrupted; and (b) submit to a physical exam when required, as provided below.

Benefits will end on the earliest of the following dates:
- The date you cease to be totally disabled;
- The date you fail to submit to a physical exam as required;
- The date your life insurance would otherwise terminate as indicated in the policy;
- The date proof of total disability is not provided when due; or
- The date you reach age 70.

Physical Exam. AIG will have the right to have a physician of its choice examine you to establish any disability. AIG will pay for the exam. You may be examined as often as reasonably necessary during the period of disability, but not more than once a year after you have been disabled for two years.

Conversion After Extension. When any applicable extension of benefits described in this section ends, you may convert to an individual insurance policy, provided you are entitled to convert as described in the conversion privilege provision.

Accelerated Life Insurance Benefit – AIG Life Insurance Company (AIG)
If you are diagnosed with a terminal condition that is reasonably expected to result in your death in six months or less, a portion of your life insurance benefit may be paid before your death. To qualify for this benefit, you must have been diagnosed as being terminally ill while insured under this policy.

Please contact the Funds Office at 1-508-533-1400 or 1-888-486-3524 for a list of qualifying conditions.

Converting Your Coverage to an Individual Policy – AIG Life Insurance Company
If your life insurance coverage ends because you are no longer eligible, you may convert your coverage to an individual life insurance policy. To convert, you must apply and pay the first premium within 31 days after your life insurance coverage terminates. No evidence of insurability will be required if you convert to an individual policy under the conversion privilege. Please apply in writing to AIG Life Insurance Company at 3600 Route 66 East, Neptune, New Jersey 07753.

Accidental Death and Dismemberment Insurance (AD&D) Plan – AIG Life Insurance Company
When a covered injury results in your accidental death or dismemberment, you or your beneficiary may be eligible to receive an AD&D benefit. AIG insures the AD&D Plan. You are eligible for this program if you meet the eligibility rules, as determined by the Trustees.

Covered employees enrolled under the Basic Benefits Plan are eligible for AD&D coverage. Covered employees enrolled under the Supplemental Benefits Plan are not eligible for AD&D coverage unless they have purchased the Bridge Plan.

Covered Benefits
Your AD&D benefit is payable according to the following schedule. AD&D death benefits are payable to the same beneficiary you name for your life insurance. Dismemberment and paralysis benefits are paid to you.

When your covered injury results in any one of the following losses within 365 days of the date of the accident, AIG will pay a benefit according to the Accidental Dismemberment Benefit.
Accidental Dismemberment Benefit
The covered employee Principal Sum is $20,000.

If injury to the Insured Person results, within 365 days of the date of the accident that caused the Injury, in any one of the losses specified below, the Company will pay the percentage of the principal sum shown below for that Loss.

If injury to the insured person results in death within 365 days of the date of the accident that caused the Injury, the Company will pay 100% of the principal sum.

<table>
<thead>
<tr>
<th>For loss of</th>
<th>Percentage of Principal Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both hands or both feet</td>
<td>100%</td>
</tr>
<tr>
<td>Sight of both eyes</td>
<td>100%</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>100%</td>
</tr>
<tr>
<td>One hand and the sight of one eye</td>
<td>100%</td>
</tr>
<tr>
<td>One foot and the sight of one eye</td>
<td>100%</td>
</tr>
<tr>
<td>Speech and hearing in both ears</td>
<td>100%</td>
</tr>
<tr>
<td>One hand or one foot</td>
<td>50%</td>
</tr>
<tr>
<td>Sight of one eye</td>
<td>50%</td>
</tr>
<tr>
<td>Speech or hearing in both ears</td>
<td>50%</td>
</tr>
<tr>
<td>Thumb and index finger of same hand</td>
<td>25%</td>
</tr>
</tbody>
</table>

If more than one loss is sustained by an insured person as a result of the same accident, only one amount—the largest—will be paid.

Paralysis Benefit
If you are injured within 365 days of the date of the accident that caused the injury, and suffer from any one of the types of paralysis specified below, AIG will pay the percentage of the principal sum shown below for that type of paralysis:

<table>
<thead>
<tr>
<th>Type of paralysis</th>
<th>Percentage of principal sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
</tr>
</tbody>
</table>

If you suffer more than one type of paralysis as a result of the same accident, only one amount, the largest, will be paid.

Seat Belt and Air Bag Benefit
Seat Belt Benefit: If an accidental death benefit is payable under the policy and the accident causing death occurs while you are operating, or riding as a passenger in, an automobile and wearing a properly fastened, original, factory-installed seat belt or, if the person is a dependent child, a properly installed and fastened child restraint device as defined by state law, AIG will pay this additional benefit. The amount payable for this additional benefit is $10,000.

Air Bag Benefit: If a seat belt benefit is payable and if you are positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact, AIG will pay an additional $10,000.

Verification of the actual use of the seat belt at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact, must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s).
Exposure and Disappearance

If, by reason of an accident covered by the Plan, you are unavoidably exposed to the elements and, as a result of such exposure, suffer a loss for which coverage is otherwise payable, that loss will be covered under the Plan.

If your body has not been found within one year of your disappearance or of the forced landing, stranding, sinking or wrecking of a conveyance in which you were an occupant, then it will be deemed, subject to all other terms and provisions of the Plan, that you have suffered loss of life within the meaning of the Plan.

AIG Benefits Travel Assist

AIG Benefits Travel Assist is a travel assistance program that offers travel medical assistance anywhere in the world with emergency referrals to hospitals and providers. AIG Benefit Travel Assist can assist with lost or stolen baggage, passports or travel documents; roadside assistance; emergency telephone interpretation; VIP concierge services; and identity theft assistance. Toll Free (within the U.S.) 1-866-315-0048. Collect/Reverse Change (outside the U.S.) +1-817-826-7105.

What the AD&D Plan Does Not Cover

The AD&D Plan does not cover any loss caused by or resulting from:

- Suicide or any attempt at intentionally self-inflicted injury;
- Sickness, disease or infections of any kind, except bacterial infections;
- Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation on a regular schedule between established airports, if you are:
  - Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
  - Performing, learning to perform, or instructing others to perform as a pilot or crew member of any aircraft; or
  - Riding as a passenger in an aircraft owned, leased, or operated by you or your employer.
- Declared or undeclared war, or any act of declared or undeclared war;
- Full-time active duty in the armed services, National Guard or organized reserve corps of any country or international authority (unearned premium for any period for which you are not covered due to your active duty status will be refunded, and loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded);
- Being under the influence of drugs or alcohol or voluntary intake of poison, drugs, gas, or fumes or intoxicants, unless taken under the advice of a physician; or
- Commission of or attempt to commit a crime.
SECTION V: Payments, Claims and Appeals

Medical and Dental Plan Coordination of Benefits

If a covered dependent has other health care coverage—such as through your spouse’s medical or dental plan—the benefits payable under this Plan will be reduced so that the total payments under all plans do not exceed 100% of this Plan’s allowable expenses, which may result in no payment being made by this Plan. The terms of each plan determine which plan pays first. Coordination of benefits provisions apply to the Medical and Dental Plans.

Whether this Plan is primary or secondary, this Plan will consider for payment only those expenses that would be covered if this Plan were the sole plan. The exception is that this Plan’s deductible can be waived to permit coordination of benefits. Participants who are covered as both enrollees and dependents under this Plan can receive coordination of benefits, but benefits that are limited by frequency or dollar limits cannot be increased. Coordination of benefits in this case will serve to pick up out-of-pocket coinsurance or co-pays; however, as previously stated, the benefits payable under this Plan will be reduced so that the total payments under all plans do not exceed 100% of this Plan’s allowable expenses, which may result in no payment being made by this Plan.

Allowable Expenses

Under coordination of benefits, allowable expenses are any expenses paid by:

- This Plan;
- Any group, blanket, franchise coverage, group service or prepayment plan providing similar benefits;
- Any governmental plan or law, including Medicare (Medicare benefits will be taken into consideration under this provision only if the expenses are covered under another plan as well as under this Plan and Medicare);
- No-fault insurance required under any law and provided through arrangements other than those already mentioned, but only to the extent of benefits required under such no-fault law;
- Any program sponsored by or arranged through a school or other educational agency or the first-party medical expense provisions of any automobile policy.

The term “plan” shall not be construed to mean any individual-type plan, student accident coverage or other student health plans when designated as an “excess only” or “always secondary” plan.

The Plan does not cover charges you incur for services when you fail to follow the rules of your primary plan. You can be reimbursed for services that are covered under this Plan that are excluded from your primary plan. If those services are subject to pre-authorization, this Plan’s rules will apply.

Order of Payment

This Plan pays first for the covered employee’s expenses. If your other coverage is through a spouse’s plan, that plan pays first for your spouse.

If your children are covered by both your own and your spouse’s plan, the primary payer will be determined by the birthday rule. That is, the plan of the parent whose birth date falls first during the calendar year will pay first. When parents are separated or divorced, if there is a court decree that establishes financial responsibility for the medical, dental or other health care expenses with respect to children, benefits are determined in agreement with the court decree. Otherwise, if the parent with custody has not remarried, that parent’s plan is primary. If the parent with custody has remarried, that parent’s plan is primary, the stepparent’s plan is secondary and the plan of the parent without custody pays third.

If these rules do not establish an order of benefit payment, the plan that has covered the person for the longer period of time is primary, except that the benefits of a plan covering the person as a laid-off or retired employee,
or dependent of a laid-off or retired employee, will be determined after the benefits of any other plan covering the person as a laid-off or retired employee, or dependent of a laid-off or retired employee, will be determined after the benefits of any other plan covering the person as an active employee. If you have coverage through active other employment, that coverage will be primary to this Plan if you are not actively at work with an employer contributing under this Plan.

Any plan that does not have a coordination of benefits provision is always considered primary and pays first.

In case of injuries sustained in a motor vehicle accident, the order of benefit determination is as follows:

- **Primary**: Any motor vehicle insurance, up to the policy’s limits
- **Secondary**: This Plan

The IUOE Local 4 Health and Welfare Fund is self-insured, as well as fully funded under the Employee Retirement Income Security Act (ERISA). Therefore, IUOE Local 4 is not subject to the state mandates and regulations related to PIP (Personal Injury Protection) coverage. Although the Plan maintains a reinsurance plan for covered services in excess of a stop loss limit, both PIP benefits and Med-Pay (Medical Payments) under the automobile policy must be exhausted before the Plan will begin paying covered medical claims and disability (LOT).

For more details regarding order of payment in case of a motor vehicle accident, contact Blue Cross Blue Shield.

### Medicare Coordination at Age 65

At age 65, you normally become eligible for Medicare benefits. As long as you continue to work or have enough hours earned from when you were working, you continue to be covered by this Plan as an active participant. Medical benefits provided by the Plan are your primary coverage (and your spouse’s, if he or she is eligible for Medicare); Medicare benefits are secondary.

In this case, you have the advantage of two plans. As long as you remain eligible for this Plan based on your active hours, your medical and dental providers should continue to submit your claims to this Plan first. After this Plan pays benefits on your behalf, your provider may submit any remaining expenses to Medicare for possible payment.

Disabled participants (as defined in federal regulations) with earned coverage through their active work hours also receive primary coverage from this Plan and secondary coverage from Medicare, as described above, until earned coverage expires.

In making a decision to enroll in Medicare Part B when you become eligible, keep the following points in mind:

- Having coverage under this Plan and under Medicare provides a greater level of protection;
- You are responsible for enrolling yourself for Medicare (and your spouse, if he or she is eligible for Medicare); and
- Consider how long you expect to work or how long your earned coverage will last. After your initial eligibility, Medicare may limit enrollment to certain times during the year, so you may not be able to enroll in Medicare when coverage under this Plan ends. The exception is if your IUOE Local 4 Health and Welfare coverage was earned based on your active work hours.

For more information about Medicare coverage, contact your local Social Security Administration office.
Coordination of Benefits (COB) Savings Bank

In situations where this Plan is secondary to another medical plan (such as with your spouse’s plan), this Plan’s costs are reduced.

The Fund has established a COB Savings Bank for every covered participant. Each year, the Fund tracks any COB savings that result from your coverage under another employer-sponsored group benefit plan and credits those savings to a separate account established on your behalf. After the end of each calendar year, the Funds Office will reimburse you 25% of your annual savings account balance, up to a maximum of $600 per family. In order to calculate this savings the Plan must receive information with your provider-submitted claims indicating how much the other carrier allowed and paid and what the remaining balance is.

If you or your dependents become covered under another employer-sponsored group insurance or benefit plan (through your spouse, for example), it is your responsibility to notify this Plan. Complete a Coordination of Benefits Form in order to report information about your other coverage. You can find a copy on the website at www.local4funds.org or request a form from Blue Cross Blue Shield.

Coordination of Benefits With No-Fault Insurance

If a covered person is injured in an automobile accident, the injury may be covered by no-fault insurance. The Fund does not cover expenses which would be covered by no-fault insurance, even if you are required to have but do not have no-fault insurance. If you or your dependents receive any money from an insurance claim, you must reimburse the Fund for payments it has made up to the net amount you receive from the insurance company.

Subrogation

Recovery of Medical Benefit, Loss of Time and Other Benefit Payments

Subrogation* and Reimbursement* of Benefit Payments

If you are injured by any act or omission of another person, the medical, loss of time and other benefits under the Fund will be subrogated. This means that the Fund and/or Blue Cross Blue Shield, as the Fund’s representative and claims administrator for medical claims, may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If you recover money, the Fund is entitled either directly or through Blue Cross Blue Shield to recover up to the amount of the benefit payments that it has made. This is true no matter where or by whom the recovered money is held or how it is designated and even if you do not recover the total amount of your claim against the other person(s). This is also true if the payment you receive is described as payment for something other than health care expenses. The amount you must reimburse this health plan will not be reduced by any attorney’s fees or expenses you incur.

Member Cooperation

With regard to medical claims, you must give Blue Cross Blue Shield, as the Fund’s medical claims administrator, information and help. With regard to loss of time and other benefit claims, you must give the Fund administrator information and help. This means you must complete and sign all necessary documents (including the Fund’s Subrogation and Constructive Trust Agreement) to help Blue Cross Blue Shield and/or the Fund get this money back on behalf of the Fund. This also means that you must give Blue Cross Blue Shield and/or the Fund timely notice of all significant steps during the negotiation, litigation or settlement with any third party (such as filing a claim or lawsuit, initiation of settlement discussions, agreement to a settlement in principle, etc.) and before settling any claim arising out of injuries you sustained by an act or omission of another person(s) for which this health plan paid benefits. You must not do anything that might limit this health plan’s right to full reimbursement.*

*See definitions of the terms Subrogation and Reimbursement in Section VI, Important Terms.
Workers’ Compensation

No coverage is provided for health care services that are furnished to treat an illness or injury that Blue Cross Blue Shield or the Fund determines was work related. This is the case even if you have an agreement with the workers’ compensation carrier that releases them from paying for the claims. All employers provide their employees with workers’ compensation or similar insurance. This is done to protect employees in case of a work-related illness or injury. All health care claims for a work-related illness or injury must be billed to the employer’s workers’ compensation carrier. It is up to you to use the workers’ compensation insurance. If Blue Cross Blue Shield pays for any work-related health care services for a participant, Blue Cross Blue Shield, on behalf of the Fund, has the right to get paid back by the party that legally must pay for the health care claims. Blue Cross Blue Shield, on behalf of this Fund, also has the right, where possible, to reverse payments made to providers. If you have recovered any benefits from a workers’ compensation insurer (or from an employer liability plan), the Fund and/or Blue Cross Blue Shield, on behalf of this Fund, has the right to recover from you the amount of benefits it has paid for your health care services or loss of time or other benefits. This is the case even if:

- The workers’ compensation benefits are in dispute or are made by means of a settlement or compromise;
- No final determination is made that an injury or illness was sustained in the course of or resulted from your employment;
- The amount of workers’ compensation due to medical or health care is not agreed upon or defined by you or the workers’ compensation carrier; or
- The medical or health care benefits or loss of time benefits are specifically excluded from the workers’ compensation settlement or compromise.

If Blue Cross Blue Shield is billed in error for these services, you must promptly call or write to the Blue Cross Blue Shield customer service office.

Loss of Time and Other Benefits Are Recovered by the Funds Office

The Plan may withhold payment of disability (loss of time) benefits and other benefits otherwise payable in connection with accidental injuries when any party other than you or this Plan may be liable for the injuries and expenses, until such liability is legally determined. You must notify the Plan in writing immediately if you make a claim against another person or entity, and you must sign a Subrogation and Constructive Trust Agreement (Agreement). If you fail to notify the Funds Office of a claim (including a simple demand for payment), or fail to sign the Agreement or otherwise cooperate in enforcement of this provision, the Fund may withhold all payment of any benefits as a result of the injury caused by the third party, and may recoup by offset or lawsuit the amount already paid.

The Fund, in its sole discretion, may make payment of medical, loss of time or other benefits before a finding of liability is made, subject to the agreement of you and your counsel, if any, to hold any proceeds from litigation, settlement or judgment in trust for the Plan and to acknowledge that the proceeds are a Plan asset in a Subrogation and Constructive Trust Agreement. Under the terms of this Plan and the Agreement, the Plan’s right to these proceeds will apply (a) even if the recovery is not sufficient to make you 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 you in connection with the recovery against the third party or the third party’s insurer pursuant to state law or otherwise (sometimes referred to as the “common fund” rule); and regardless 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); and (b) even if the recovery was reduced due to your negligence (sometimes referred to as “contributory negligence”), or any other common law defense.
How to File Claims and Appeal Denied Claims

When you receive covered services from participating network providers, you do not have to file a claim. Network providers are responsible for filing claims and are paid directly. Network providers file claims directly to Blue Cross Blue Shield, CVS/Caremark, Delta Dental, Davis Vision and EPIC Hearing Health USA.

If you receive covered health services from a provider of Holistic Benefits, for a DOT physical or for other services in which the provider will not file a claim on your behalf, you may be responsible for filing a claim with Blue Cross Blue Shield if the out-of-network provider will not file claims on your behalf.

Your network and out-of-network health care provider may submit standard claim forms or submit most claims electronically. Your out-of-network provider may provide you with a standard claim form, or you may submit the actual receipt to the Plan.

If you have already paid all or a portion of the fees for service to the out-of-network provider, indicate the amount on the claim form or receipt.

Send participant-submitted medical claims to:
Blue Cross Blue Shield of Massachusetts, Local Claims Department
P.O. Box 986030
Boston, MA 02298

Send loss of time claims to:
IUOE Local 4 Funds
16 Trotter Drive, P.O. Box 660
Medway, MA 02053-0660

Send claims for out-of-network dental providers to:
Delta Dental of Massachusetts
465 Medford Street
Boston, MA 02129

Send claims for out-of-network vision providers to:
Davis Vision – Vision Care Processing Unit
P.O. Box 971
Schenectady, NY 12301

Providers will send claims for hearing services by EPIC Hearing Health providers to:
EPIC Hearing Healthcare
17870 Castleton Street
City of Industry, CA 91748

You will receive an explanation of benefits (EOB) showing what the Plan covered. You may receive a bill from the provider for any remaining expense, which will be your responsibility to pay.

Benefits for covered services submitted by providers will be paid to the provider if the provider has completed the assignment of benefits section of the claim. You are responsible for payment of services and supplies not covered by the Plan to the provider of service.

To be eligible for reimbursement under the Plan, your claim must be submitted within 12 months of the date of service.

If your claim for benefits is denied, you have the right to appeal.
Claims Procedures (In General)

Claims are divided into the following categories:

• Urgent care claims;
• Concurrent care claims;
• Pre-service claims;
• Post-service claims; and
• Disability (loss of time) claims.

Special time frames apply to each type of claim, as described in the following section. Generally, vision, dental and hearing claims are post-service claims.

Urgent care claims encompass services that require notification or approval before receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function, or, in the opinion of a physician (or dentist) with knowledge of your medical (or dental) condition, could cause severe pain.* Provided Blue Cross Blue Shield receives all necessary information, taking into account the seriousness of your condition, you will receive notice within 72 hours of the benefit request. A denial of benefits may be oral, with a written or electronic confirmation to follow within three days.

If you or your representative files an urgent care claim improperly, you will be notified and advised how to correct it within 24 hours after the urgent care claim is received. This notification may be oral, unless you or your representative request written notification.

If you are required to provide additional information in order to process your claim, you will be notified of the information needed within 24 hours after the claim is received. You will then have 48 hours to provide the requested information.

You will be notified of a decision within 48 hours after receiving the requested additional information, or at the end of the 48-hour period within which you were to provide the required additional information (if it isn’t received).

*For purposes of an urgent care claim, the following will be acknowledged as your authorized representative: a physician or other health care professional who is licensed, accredited or certified to perform specified health services consistent with state law, and who has knowledge of your medical or dental condition.

Concurrent Care Claims

If you are undergoing a course of treatment that was previously approved for a specific period of time or number of treatments and your request to extend treatment is urgent as defined above, a decision will be made within 24 hours. You must, however, make your request at least 24 hours prior to the end of the approved treatment.

A determination will be made within 24 hours of the receipt of your request. If your request is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and the above urgent care time frames for a decision will apply.

If your request to extend treatment does not meet the definition of urgent care as defined above, your request will be considered a new claim and decided according to post-service or pre-service time frames, whichever applies.

Pre-Service Claims

These are claims that require you to provide notice to the claims administrator for approval before receiving care. They generally are medical claims.

Provided you submit your pre-service claim properly with all required information, you or your representative will receive written notice of the claim decision within 15 days of receipt of your claim. If you submit your pre-service claim improperly, within five days of receiving your claim you will be notified how to correct your claim including needed information. The 15-day review period may be extended for an additional 15 days if necessary due to circumstances beyond the control of the claims administrator, and you will be notified of the circumstances requiring the extension of time and the date by which a decision is expected.

If you are required to provide additional information in order to process your pre-service claim, you will be notified of the information needed within 15 days of receipt of your claim and your claim will be held until all required information is received.
If an extension of the review period is due to your failure to submit information necessary to review the claim, you will have 45 days to provide the requested information. If that information is received within the 45-day time frame, you will be notified of the determination of your claim within 15 days after the information is received. If you don’t provide the needed information within the 45-day period, your claim will be denied or decided based on the information submitted.

**Post-Service Claims**
In the case of a post-service claim filed by you, you or your representative will receive written notification of the Plan’s determination within 30 days after receipt of the claim or receipt of any information requested by the Plan as necessary to decide the claim.

The period may be extended an additional 15 days when necessary due to matters beyond the control of the Plan, and provided that prior to the expiration of the initial 30-day period, you or your representative is notified of the circumstances that require the extension.

If the extension is due to your failure to submit information necessary to decide the claim, the notice will specifically describe the information necessary to complete the claim and you will be allowed at least 45 days from receipt of the notice to provide the information. The claim will be decided within 15 days following the earlier of (1) the date the needed information is received or (2) the end of the 45-day period for providing the needed information.

**Disability Claims (Loss of Time)**
In the case of a loss of time claim, a determination of disability will be made within 45 days of the date the Fund receives all necessary documentation. A benefit determination could be extended for an additional 30 days, provided that the Plan determines that such an extension is necessary due to matters beyond its control, and that the Plan notifies you before the expiration of the initial 45-day period explaining why the extension is necessary. If after this 45-day extension a determination still cannot be made, an additional 30-day extension may be required, in which case you will be notified before the end of the first 30-day extension of the circumstances for the extension and the date by which a decision is expected. The notice of extension will explain the standards upon which entitlement to a benefit are based, the unresolved issues that prevent a decision, and the additional information needed to resolve those issues. You will be given at least 45 days after receiving the notice to furnish the specified information.

**Your Claim Denial Notice**
If your initial claim is denied, in whole or in part, you or your representative will receive written notice. The notice will explain the reason for the denial, the specific Plan provision(s) on which the denial is based, a description of any additional information or material necessary to perfect the claim, and an explanation of why the information or material is necessary, and a description of the Plan’s appeal or review procedures and applicable time limits, including a statement of your right to bring a civil action under ERISA Section 502(a) following a denial on appeal. The notice also will include a statement of your right to review documents and other information related to your claim after making appropriate arrangements, or receive copies of such documents or information free of charge. If the denial was based on an internal rule, guideline, protocol or similar criteria, the notice will contain a statement that the rule, guideline, protocol or criteria was relied on and that a copy will be provided to you upon request at no charge. If the determination was based on a medical necessity, based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available at no extra charge upon request.
How to Appeal Denied Prescription Drug, Dental, Vision, Disability (Loss of Time) and Hearing Claims

To appeal a denied claim or to review administrative documents pertinent to the claim, send a written request to the Health and Welfare Plan. When submitting an appeal, state the reason you think your claim should be reviewed and include any data, documents, questions or comments, along with copies of all bills and claim forms relating to your claim.

You must file your appeal within 180 days of the date of the denial of the claim. You are encouraged to file earlier.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical judgment, a reconsideration review will be done in consultation with a health care professional who was not involved in the prior determination and who has appropriate expertise in the field. It is understood that you consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. Appeals are divided into the following categories: urgent care claims, concurrent care claims, pre-service claims, post-service claims and disability claims. Special time frames apply to the responses to each type of appeal, as described in this section.

- **Urgent Care Claims** – If an urgent care claim is denied, in whole or in part, you or your representative may appeal the determination following receipt of the adverse determination. You may appeal orally or in writing. You are entitled to an expedited review. You or your representative will receive written notification of a benefit determination within 72 hours of receipt of your request for review of the denied claim.

- **Concurrent Care Claims** – If a concurrent care course of treatment was previously approved, any reduction or termination of the course of treatment before the end of the time or the completion of the specified number of treatments will be deemed an adverse benefit determination. In this case, you will receive sufficient advance notification of the reduction or termination to permit you to appeal before the reduction or termination and the Plan will respond with a determination on review of the denial in a timely manner.

- **Pre-Service Claims** – If a pre-service claim is denied, in whole or in part, you or your representative may appeal the determination within 180 days following the receipt of the adverse determination. You will receive a determination of the review of the denied claim within 30 days of receipt of your request for review of the denial.

- **Post-Service Claims** – If a post-service claim is denied, in whole or in part, you or your representative may appeal the determination within 180 days following receipt of the adverse determination. You will receive a determination of the review of the denied claim within 60 days of receipt of your request for review of the denial.

- **Disability Claims** – If a disability claim is denied, in whole or in part, you or your representative may appeal the determination within 180 days following receipt of the denial. You will receive a determination within 45 days of receipt of your appeal.

If you are not satisfied with the first-level appeal decision, you have the right to request a second-level appeal from the Board of Trustees. Your second-level appeal request must be submitted to the Board of Trustees within 60 days from receipt of the first-level appeal decision. An appeal decision by the Board of Trustees could be delayed to the next meeting of the Appeals Subcommittee or the next Trustees’ meeting following the Plan’s receipt of the request for review. If the request arrives less than 30 days before the next Appeals Subcommittee meeting or the next Trustees’ meeting, the determination will be made no later than the date of the second meeting following receipt of the request, unless special circumstances require more time to review your appeal. If the Board of Trustees needs more time, you will be provided with written notification of the extension, and a decision on your appeal will be made no later than the third meeting of the Board of Trustees immediately following the receipt of the appeal. The decision on any appeal or review of your claim by the Trustees will be given to you in writing within five days after the Trustees rule on the appeal.
No civil action may be brought unless you exhaust your internal appeals within the Plan. If your appeal before the Board of Trustees is denied, you have the legal right to bring a civil action under Section 502(a) of ERISA within 60 days of the date of the letter informing you of the denial of the appeal by the Trustees.

The notice of a denial of any appeal will include: the specific reason(s) for the determination; reference to the specific Plan provision(s) on which the determination is based; a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge; and a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review. If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on a medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

If the appeal of the initial benefit determination is based in whole or in part on a medical judgment, including a decision that a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Fund must consult with a health care professional who has appropriate training and experience in the field of medicine involved. In such a case, the health care professional will not be the same individual (nor a subordinate of any such individual) whose advice was obtained by the Fund in connection with the initial adverse benefit determination. In addition, the Fund will identify, upon request, any medical or vocational expert 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.

How to Appeal a Denied Medical Claim

Please note: Rhode Island residents should also review the section entitled How to File an Appeal and Appeals Process for Rhode Island Residents or Services.

Blue Cross Blue Shield has assumed responsibility for the process of reviewing denied medical claims. If you are denied coverage or payment for services you received, you disagree with how your claim was paid, or you have a complaint about the care or service you received, you should first call the Blue Cross Blue Shield phone number on the back of your ID card. If you still disagree with the decision after your phone conversation with a Blue Cross Blue Shield representative, you may request a review of your grievance first through the Blue Cross Blue Shield Internal Formal Grievance Review.

Internal Formal Grievance Review

To request a formal review of your grievance, put your grievance in writing and mail, fax or email it to Blue Cross Blue Shield at one of the following addresses: (mail) Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; (fax) 617-246-3616; (email) grievances@bcbsma.com. You will receive confirmation of receipt of your grievance by mail or fax within 15 calendar days, or immediately if the grievance is sent by email. Alternatively, you may submit your grievance by phone by calling the Blue Cross Blue Shield Member Grievance Program at 1-800-472-2689.

Once your request is received, Blue Cross Blue Shield will research the case in detail. They will ask for more information if it is needed. Blue Cross Blue Shield will let you know in writing of the decision or the outcome of the review. If your grievance is about termination of your coverage for concurrent services that were previously approved by Blue Cross Blue Shield, the disputed coverage will continue until this grievance review process is completed. This continuation of your coverage does not apply: to services that are limited by a dollar or visit maximum and that exceed that benefit limit; to non-covered services; to services that were received prior to the time that you requested a formal grievance review; or when a grievance is not received on a timely basis, based on the course of treatment.
All grievances must be received by Blue Cross Blue Shield within one year of the date of treatment, event or circumstance, such as the date you were told of the service denial or claim denial.

Your request for a formal grievance review should include: the name, ID number and daytime phone number of the member asking for the review; a description of the problem; all relevant dates; names of health care providers or administrative staff involved; and details of the attempt that has been made to resolve the problem. If Blue Cross Blue Shield needs to review the medical records and treatment information that relate to your grievance, Blue Cross Blue Shield will promptly send you an authorization form to sign if needed. You must return this signed form to Blue Cross Blue Shield to allow for the release of your medical records. You also have the right to look at and get copies (free of charge) of records and criteria that Blue Cross Blue Shield has and that are relevant to your grievance, including the identity of any experts who were consulted.

You may choose to have another person (authorized representative) act on your behalf during the grievance review process. You must designate this person in writing to Blue Cross Blue Shield, or, if you are not able to do so, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative or may appoint another party to be the authorized representative. (When you are an inpatient, a health care provider may act as your authorized representative to ask for an expedited grievance review. In this case, you do not have to designate the health care provider in writing.)

All grievances are reviewed by professionals who are knowledgeable about Blue Cross Blue Shield and the issues involved in the grievance. The professionals who will review your grievance will not be those who participated in any of Blue Cross Blue Shield’s prior decisions regarding the subject of your grievance, nor do they work for anyone who did. When a grievance is related to a medical necessity denial, at least one grievance reviewer is an individual who is an actively practicing health care professional in the same or a similar specialty who usually treats the medical condition or performs the procedure or provides treatment that is the subject of your grievance.

The review and response for Blue Cross Blue Shield’s internal formal grievance review will be completed within 30 calendar days from the day you tell Blue Cross Blue Shield that you disagree with its answer and would like a formal grievance review. With your permission, Blue Cross Blue Shield may extend the 30-calendar-day time frame to complete a grievance review. This will happen in those cases when Blue Cross Blue Shield and the member agree that additional time is required to fully investigate and respond to the grievance.

Blue Cross Blue Shield may also extend the 30-calendar-day time frame when the grievance review requires a review of your medical records and Blue Cross Blue Shield requires your authorization to get these records. The 30-day response time will not include the days from when Blue Cross Blue Shield sends you the authorization form to sign until it receives your signed authorization form (if needed). If Blue Cross Blue Shield does not receive your authorization within 30 working days after your grievance is received, Blue Cross Blue Shield may make a final decision about your grievance without that medical information. In any case, for a grievance review involving services that have not yet been obtained by you, Blue Cross Blue Shield will ask for your permission to extend the 30-day time frame if it cannot complete the review within 30 calendar days of receipt of your grievance.

Once the grievance review is completed, Blue Cross Blue Shield will let you know in writing of the decision or the outcome. If Blue Cross Blue Shield continues to deny coverage for all or part of a health care service or supply, Blue Cross Blue Shield will send an explanation to you. This notice will include: information related to the details of your grievance; the reasons that Blue Cross Blue Shield has denied the request and the applicable terms of your coverage in this Health Plan; the specific medical and scientific reasons for which Blue Cross Blue Shield has denied the request; any alternative treatment or health care services and supplies that would be covered; Blue Cross Blue Shield clinical guidelines that apply and were used and any review criteria; and how to request an external review.

You have the right to look at and get copies of records and criteria that Blue Cross Blue Shield has and that are relevant to your grievance. These copies will be free of charge. Blue Cross Blue Shield will maintain a record of all formal grievances, including the response for each grievance review, for up to seven years.
Expedited Review for Immediate or Urgently Needed Services. In place of the formal grievance review described above, you have the right to request an “expedited” review right away when your grievance review concerns medical care or treatment for which waiting for a response under the grievance review time frames described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by Blue Cross Blue Shield or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance review. If you request an expedited review, Blue Cross Blue Shield will review your grievance and notify you of the decision within 72 hours after your request is received, or such shorter time period as required by federal law.

External Review
You must first go through the Blue Cross Blue Shield internal formal grievance process as described above. The Blue Cross Blue Shield internal grievance review decision may be to continue to deny all or part of your coverage in this Health Plan. In this case, you may be entitled to a voluntary external grievance review. You are not required to pursue an external grievance review. Your decision whether to pursue an external grievance review will not affect your other coverage. If you receive a grievance denial letter from Blue Cross Blue Shield in response to your internal grievance review, the letter will tell you what steps you can take to file a request for an external grievance review. If you decide to request an external grievance review, you must file your request within the four months after you receive the denial letter from Blue Cross Blue Shield. Blue Cross Blue Shield will work closely with you to guide you through the external grievance review process.

You (or your authorized representative) have the right to request an expedited external review when your situation is for immediate or urgently needed services as follows:

- When your grievance concerns medical care or treatment for which waiting for a response under the standard (non-expedited) external grievance review time frames would seriously jeopardize your life or health or your ability to regain maximum function; or
- When your grievance concerns an internal grievance review final adverse benefit determination for an admission, availability of care, continued stay or health care services for which you received emergency services, while you are an inpatient.

External Review Process
When Blue Cross Blue Shield receives your request for an external review, your case will be referred to an external review agency to complete your external review. You (or your authorized representative) will be notified by the external review agency of your eligibility and acceptance for an external review. In some cases, the review agency may need more information about your grievance, and if so, they will request it from Blue Cross Blue Shield, you or your authorized representative.

The review agency will consider all aspects of the case and send a written response of the outcome. They will send the response to you (or your authorized representative) and to Blue Cross Blue Shield within 45 days of receiving the request. If the agency determines additional time is needed to fully and fairly evaluate the request, the agency will notify you and Blue Cross Blue Shield of the extended review period. In the case of an expedited review, you will be notified of their decision within 72 hours. This 72-hour period starts when the external review agency receives your case.

If the review agency overturns Blue Cross Blue Shield’s decision in whole or in part, Blue Cross Blue Shield will send you (or your authorized representative) a notice of the review decision made by the agency. This notice will confirm the decision of the review agency. It will also tell you (a) what steps or procedures you must take (if any) to obtain the requested coverage or services; (b) the date by which Blue Cross Blue Shield will pay for or authorize the requested services; and (c) the name and phone number of the person at Blue Cross Blue Shield who will make sure your grievance is resolved.

How to Request an External Review
To request an external review, you must complete the external review request form that is provided with the grievance denial letter you receive from Blue Cross Blue Shield. Once your external review request form is completed, you must send it to Blue Cross Blue Shield as shown on the form.
The decision made by way of the external review process will be accepted as final.

You have the right to look at and get copies of records and criteria that Blue Cross Blue Shield has and that are relevant to your grievance. These copies will be free of charge.

How to File an Appeal, and Appeals Process for Rhode Island Residents or Services

You may also have the right to appeal as described in this section when your claim is denied as being not medically necessary for you. If so, these rights are in addition to the other rights to appeal that you have that are described above. The following provisions apply only to:

• A member who lives in Rhode Island and who is planning to obtain services which Blue Cross Blue Shield has determined are not medically necessary.
• A member who lives outside of Rhode Island and who is planning to obtain services in Rhode Island which Blue Cross Blue Shield has determined are not medically necessary.

Blue Cross Blue Shield decides which covered services are medically necessary for you by using its medical necessity guidelines. Some of the services that are described in this benefit booklet may not be medically necessary for you. If Blue Cross Blue Shield has determined that a service is not medically necessary for you, you have the right to the following appeals process:

Reconsideration

A reconsideration is the first step in this process. If you receive a letter from Blue Cross Blue Shield that denies payment for your health care services, you may ask that Blue Cross Blue Shield reconsider its decision. You must do this by writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. You must send your request within 180 days of Blue Cross Blue Shield’s adverse decision. Along with your letter, you should include any information that will support your request. Blue Cross Blue Shield will review your request. Blue Cross Blue Shield will let you know the outcome of your request within 15 calendar days after it has received all information needed for the review.

Appeal

An appeal is the second step in this process. If Blue Cross Blue Shield continues to deny coverage for all or part of the original service, you may request an appeal. You must do this within 60 days of the date that you receive the reconsideration denial letter from Blue Cross Blue Shield. Your appeal request should include any information that supports your appeal. You may also inspect and add information to your Blue Cross Blue Shield case file to prepare your appeal. In accordance with Rhode Island state law, if you wish to review the information in your Blue Cross Blue Shield case file, you must make your request in writing and you must include the name of a physician who may review your case file on your behalf. Your physician may review, interpret, and disclose any or all of that information to you. Once received by Blue Cross Blue Shield, your appeal will be reviewed by a health care provider in the same specialty as your attending provider. Blue Cross Blue Shield will notify you of the outcome of your appeal within 15 calendar days after it has received all information needed for the appeal.

External Appeal

If your appeal is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with Blue Cross Blue Shield. If you request this voluntary external appeal, Rhode Island requires that you pay for half of the cost of the appeal. Your group will pay for the remaining half. The notice you receive from Blue Cross Blue Shield about your appeal will advise you of: the name of the appeals agency that is designated by Rhode Island; and your share of the cost for an external appeal. To file an external appeal, you must make your request in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Along with your request, you must: state your reason(s) for your disagreement with Blue Cross Blue Shield’s decision; and enclose a check made payable to the designated appeals agency for your share of the cost for the external appeal.

Within five working days after Blue Cross Blue Shield receives your written request and payment for the appeal, Blue Cross Blue Shield will forward your request to the external appeals agency. Blue Cross Blue Shield will also send your group’s portion of the fee and your entire Blue Cross Blue Shield case file. The external appeals agency will notify you in writing of the decision within 10 working days of receiving all necessary information.
**Expedited Appeal**

If your situation is an emergency, you have the right to an “expedited” appeal at all three levels of appeal as stated above. An emergency is defined as the sudden onset of a medical or mental condition that in the absence of immediate medical attention could reasonably be expected to result in placing your health or your ability to regain maximum function in serious jeopardy or, in your physician’s opinion, would result in severe pain. You may request an expedited reconsideration or appeal by calling Blue Cross Blue Shield at the phone number shown in your letter. Blue Cross Blue Shield will notify you of the result of your expedited appeal within two working days or 72 hours of its receipt, whichever is sooner, or such shorter time period as required by federal law. If your appeal is denied, you have the right to request an expedited external appeal. The notice you receive from Blue Cross Blue Shield about your appeal will advise you of: the name of the appeals agency that is designated by Rhode Island; and the amount that Rhode Island requires you pay for your share of the cost for an expedited external appeal. To request an expedited external appeal, you must send your request in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Your request should state your reason(s) for your disagreement with the decision and include signed documentation from your provider that describes the emergency nature of your treatment. In addition, you must also enclose a check made payable to the designated appeals agency for your share of the cost for the expedited external appeal.

Within two working days after the receipt of your written request and payment for the appeal, Blue Cross Blue Shield will forward your request to the external appeals agency along with your group’s portion of the fee and your entire Blue Cross Blue Shield case file. The external appeals agency will notify you in writing of the decision within two working days or 72 hours, whichever is sooner, of receiving your request for a review.

**External Appeal Final Decision**

If the external appeals agency upholds the original decision of Blue Cross Blue Shield, this completes the appeals process for your case. But if the external appeals agency reverses Blue Cross Blue Shield’s decision, the claim in dispute will be reprocessed by Blue Cross Blue Shield upon receipt of the notice of the final appeal decision. In addition, Blue Cross Blue Shield will repay you for your share of the cost for the external appeal within 60 days of the receipt of the notice of the final appeal decision.

**Final Voluntary Appeal Before Fund’s Board of Trustees**

After you have exhausted the Blue Cross Blue Shield internal and external appeal processes described above, you may also submit an appeal directly to the IUOE Local 4 Health and Welfare Fund for a final determination by its Board of Trustees. If you wish to do so, you must send your written request for review within 60 days of your receipt of the final level Blue Cross Blue Shield decision to: Board of Trustees, IUOE Local 4 Health and Welfare Fund, PO Box 660 Medway, MA 02053. For assistance, call the Funds Office at 1-888-486-3524.

An appeal decision by the Board of Trustees could be delayed until the next meeting of the Appeals Subcommittee or the next Board of Trustees’ meeting following the Plan’s receipt of the request for review. If the request arrives less than 30 days before the next Appeals Subcommittee meeting or the next Trustees’ meeting, the determination will be made no later than the date of the second meeting following receipt of the request, unless special circumstances require more time to review your appeal. If the Board of Trustees needs more time, you will be provided with written notification of the extension, and a decision on your appeal will be made no later than the third meeting of the Board of Trustees immediately following the receipt of the appeal.
The decision on any appeal or review of your claim by the Trustees will be given to you in writing within five days after the Trustees rule on the appeal. The notice of a denial of a claim on review/appeal will include: the specific reason(s) for the determination; reference to the specific Plan provision(s) on which the determination is based; a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge; and a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review. If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on a medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

If the appeal of the initial benefit determination is based in whole or in part on a medical judgment, including a decision that a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Fund must consult with a health care professional who has appropriate training and experience in the field of medicine involved. In such a case, the health care professional will not be the same individual (nor a subordinate of any such individual) whose advice was obtained by the Fund in connection with the initial adverse benefit determination. In addition, the Fund will identify, upon request, any medical or vocational expert 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.

**Legal Action**

Before you pursue a legal action against Blue Cross Blue Shield for any claim under this Health Plan, you must complete the Blue Cross Blue Shield internal formal grievance review described above. You may, but you do not need to, complete an external review and/or appeal to the Fund’s Board of Trustees before you pursue legal action. If, after you complete the grievance review, you choose to bring a legal action against Blue Cross Blue Shield, you must bring this action within two years after the cause of the action arises. For example, if you are filing a legal action because you were denied a service or you were denied a claim for coverage from this Health Plan, you will lose your right to bring a legal action against Blue Cross Blue Shield unless you file your action within two years after the date of the decision of the final internal appeal of the service or claim denial. If your appeal is denied, and you file an appeal with the Board of Trustees, you have the legal right to bring a civil action under Section 502(a) of ERISA against the Fund within 60 days of the date of the letter informing you of the final denial of the appeal by the Trustees.
How to File Life Insurance and AD&D Claims

To file a life insurance claim, you or your beneficiary should contact the Funds Office as soon as possible after the loss occurs.

For a death claim, a copy of the death certificate will be required. The Funds Office will file the claim with AIG (for life insurance claims) on your own or your beneficiary’s behalf.

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<th>To file a claim for:</th>
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<td>Phone: 1-800-250-8898</td>
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If AIG denies payment of your claim, you will receive written notice within 90 days of the date the insurance company receives your claim or physician’s statement, if filed later. An extension of 90 days will be allowed for processing your claim if special circumstances are involved. AIG will notify you in writing of any extension it requires to review your claim, including the special circumstances involved and the date by which it expects to reach a decision.

If AIG denies your claim, the notice will be written in an understandable manner and will include:

- The specific reasons for the denial;
- Specific references to the Plan provision on which the denial is based; and
- An explanation of the claim review procedure.

You may request an appeal at any time during the 60-day period following the date you receive the notice of denial.

No civil action may be brought unless you exhaust your internal appeals with AIG. If your appeal to AIG is denied, you have the legal right to bring a civil action under Section 502(a) of ERISA within three years of the date proof of loss must be submitted.

How to Appeal a Denied Life Insurance and AD&D Insurance Claim

AIG, the Life Insurance and AD&D Insurance carrier, considers requests for an appeal of a denied claim when you or your duly authorized representative makes a written request for review. You may review pertinent documents and submit to AIG a written statement of issues and comments. Review of claim denials and final decisions on appeal are AIG’s responsibility for the Life Insurance and AD&D Insurance Plans.

AIG serves as the claims review fiduciary with respect to the Life Insurance and AD&D Insurance policies and Plans. For both the Life Insurance and AD&D Insurance Plans, the claims review fiduciary has the final discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary will be complete, final and binding on all parties.
SECTION VI: Important Terms

To receive the highest level of benefits payable under the Plan, you must understand how the Plan works. Before you receive care, be sure you understand the important terms explained in this section. The following words and phrases are not intended to imply that coverage for them is available under the Plan unless specified. The schedule of benefits states the applicable coverage.

**Accident:** An unforeseen or unexplained sudden injury occurring by chance without intent or volition.

**Active Employee:** A person who meets the definition of covered employee and who is engaged in covered employment.

**Alcoholism:** An alcohol-induced disorder which produces a state of psychological and/or physical dependence.

**Ambulatory Surgical Center:** A specialized facility:
- Where coverage of such facility is mandated by law, has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located, or
- Where coverage of such facility is not mandated by law, which meets all of the following requirements:
  - It is established, equipped and operated in accordance with the applicable laws in the jurisdiction in which it is located, primarily for the purpose of performing surgical procedures;
  - It is operated under the supervision of a licensed doctor of medicine (MD) or doctor of osteopathy (DO) who is devoted full time to such supervision, and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one hospital (as defined) in the area;
  - It requires in all cases other than those requiring only local infiltration anesthetics that a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure;
  - It provides at least two operating rooms and at least one post-anesthesia recovery room and is equipped to perform diagnostic X-ray and laboratory examinations;
- It provides the full-time services of one or more registered nurses (RNs) for patient care in the operating room and in the post-anesthesia recovery room;
- It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications or require post-operative confinement; and
- It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report, and a discharge summary.

**Birthing Center:** A licensed facility run by at least one physician specializing in obstetrics and gynecology. It must accept only low-risk pregnancies, extend staff privileges to physicians practicing obstetrics and gynecology at a local hospital, have at least two beds or rooms for labor and delivery, provide (or arrange) diagnostic X-rays and lab tests, administer local anesthesia and perform minor surgery, keep records of each patient and child, be able to arrange emergency transfers to a local hospital, and have an ongoing quality assurance program. A physician or certified nurse-midwife must be present at and immediately after delivery, full-time skilled nursing services must be provided directly by a registered nurse (RN) or certified nurse-midwife, and trained staff must be present to handle emergencies and provide life support services.

**Child:** Includes your natural children, legally adopted children, children placed with you for adoption, stepchildren through a current marriage,* children for whom you are given legal guardianship, foster children or other children who meet the Plan’s eligibility requirements, as previously described.

*If your stepchild is covered by the Plan and then you divorce the biological parent of the stepchild, and you are not the legal guardian or adoptive parent of the stepchild, the stepchild is no longer eligible for coverage.
Clinical Efficacy: Shall mean that the treatment satisfies both of the following:
• It can reasonably be expected to improve survival, health or function or to alleviate symptoms of or stabilize that condition, and
• Its use outweighs any potential harm.

Coinsurance: The percentage amount you must pay for care, often after you satisfy your annual deductible. You pay a different level of coinsurance for in-and out-of-network benefits.

Collective Bargaining Agreement: The contract(s), as amended, between the International Union of Operating Engineers, Local 4 and any employer or any employer association covering wages, hours and conditions of employment requiring contributions to this Plan.

Co-pay: The pre-determined fee you pay when you receive certain in-network services. Generally, you pay your co-pay directly to the provider when you receive the care.

Cosmetic: A treatment will be considered cosmetic for either of the following reasons:
• Its primary purpose is to beautify, or
• There is no documentation of a clinically significant impairment, which means the decrease in function or change in physiology due to illness, injury or congenital abnormality.

Covered Employee: A person in a job category covered by a collective bargaining agreement or participation agreement on whose behalf an employer makes the required contributions to the Plan.

Covered Employment: Covered Employment means employment by an employer at employment for which such employer has agreed to contribute to the Fund under a Collective Bargaining Agreement with the Union or Participation Agreement and shall include the employment of the Office Employees of the Union, IUOE Local 4 Annuity and Savings Fund, the IUOE Local 4 Apprenticeship and Training Fund, the IUOE Local 4 Health and Welfare Fund, and the IUOE Local 4 Pension Fund for whom contributions are required to be made by the Funds, and shall include credit for such employment associated with the administration of the Fund prior to the establishment of the Funds and shall include the employees of any other entity for whom contributions are required to be made to the Funds.

Covered Person: An employee or dependent who is eligible to receive benefits under this Plan.

Custodial Care: With respect to a specific condition, means a level of care:
• If its clinical efficacy has not been generally accepted by the medical community in the United States; and
• The care is chiefly designed to assist a person in the activities of daily living; and
• The care is not required by state law to be provided by a licensed professional.

Activities of Daily Living include but are not limited to:
• Judgment/cognitive function
• Writing
• Reading
• Communications
• Bathing
• Eating
• Toileting
• Dressing
• Transfer from bed
• Transfer from toilet
• Bowel and bladder control
• Managing money
• Taking medications
• Using public transportation
• Sitting

Deductible: The annual dollar amount you and each covered dependent must pay for eligible medical expenses before the Plan pays benefits. Your annual deductible applies to out-of-network benefits provided under the Plan and certain in-network hospital or physician benefits or durable medical equipment.
A family deductible is met when your family’s total deductible expenses reach a certain level in a calendar year. Although there is a per-individual deductible, the Plan will never take more than two full individual deductibles per family. This means that family members can combine their eligible charges to meet the family deductible, but the Plan will never take more than the individual deductible from any one person.

**Dental Services:** Procedures involving the teeth, gums or supporting structures.

**Dentist:** A duly licensed dentist practicing within the scope of the dental profession and any other physician furnishing any dental services which such physician is licensed to perform.

**Drug Addiction:** A substance-induced disorder that produces a state of psychological and/or physiological dependence.

**Drug Addiction/Alcoholism Treatment Facility:** A public or private facility providing services especially for the detoxification or rehabilitation of drug addicts or alcoholics licensed for those services. A comprehensive health service organization, community mental health center, or other mental health clinic or day care center that furnishes mental health services with the approval of the appropriate governmental authority, and the public or private facility or portion thereof providing services especially for the rehabilitation of drug addicts or alcoholics and that is licensed for those purposes.

**Durable Medical Equipment:** Those devices that are necessary for the alleviation or correction of defects, including arm and leg braces; artificial arms, legs and eyes; crutches; hospital beds; pressure machines, resuscitators; traction equipment; walkers; and wheelchairs. It does not mean appliances such as air conditioners, air purifiers, arch supports, articles of special clothing, corrective shoes, humidifiers or dehumidifiers, dentures, elevators, eyeglasses, hearing aids, heating pads, hot water bottles, exercise equipment or devices, whirlpool baths, ramps or handrails, items of furniture, or similar devices.

**Eligible Dependents:** Includes the following:
- Your lawful spouse, provided he or she is not legally divorced from you.
- Your married or unmarried child up to age 26, provided he or she is not otherwise eligible for his or her own group health insurance coverage through an employer (including through the child’s spouse’s employer, if any). Note that after January 1, 2015, your child under age 26 is an eligible dependent even if he or she is eligible for his or her own employer-based group health coverage.
- A mentally or physically handicapped unmarried child over the age of 26 who became incapable of self-support prior to age 26, regardless of current age, for whom you are at least 50% responsible for support and maintenance.

For Plan purposes, the term “child” or “children” includes your natural children, legally adopted children, children placed with you for adoption, stepchildren through a current marriage,* foster children, children for whom you have legal guardianship or other children who meet the Plan’s eligibility requirements.

A spouse is defined as an individual to whom you are legally married under the laws of the state in which the marriage occurred.

*If your stepchild is covered by the Plan and then you divorce the biological parent of the stepchild, and you are not the legal guardian or adoptive parent of the stepchild, the stepchild is no longer eligible for coverage.

**Eligible Employee:** A covered employee who has met the eligibility requirements of the Plan.

**Eligible Expense:** Any service or supply prescribed by a physician that is medically necessary for the treatment of any illness or injury. The service must be listed as a covered service by the Plan.

**Emergency:** The sudden onset of an illness or injury requiring immediate medical attention.

**Employee:** All employees who work the prescribed hours set forth in the eligibility section and referred to as covered employees.
**Experimental or Investigational Services:** Drugs, devices, medical treatments or procedures, including complications that arise as a result of any of these treatments or procedures. The Plan does not provide coverage for anything considered experimental or investigational and determined as not covered by Blue Cross Blue Shield of Massachusetts Medical Policies. Also, the Plan does not cover ancillary services, drugs, devices, medical treatments or procedures that would otherwise be covered when done in support of experimental or investigational procedures. However, at the Fund’s sole discretion, on a case-by-case basis, diagnostic tests such as laboratory, pathology, or X-ray services or office visits that are not otherwise covered when provided under a qualified clinical trial can be covered.

For Plan purposes, experimental or investigational means:

- The drug or device requires approval of the Food and Drug Administration (FDA) and the drug or device has not been approved when furnished (a drug or device approved for investigational use is deemed to be experimental or investigational).
- Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials; is in the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy compared with a standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety or its efficacy as compared with a standard means of treatment or diagnosis for the patient’s medical condition.

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

**Experimental or Investigative** shall mean any treatment unless it is generally accepted by the medical community in the United States and, as compared to accepted alternative treatments for that condition, can reasonably be expected to: (1) result in similar or improved survival, health or function, or (2) alleviate symptoms of or stabilize the condition. However, the following are not considered experimental or investigative:

- **Transplants:** Any human solid organ or bone marrow/stem cell transplant provided that:
  a) The condition is life-threatening;
  b) Such transplant for that condition is the subject of an ongoing Phase III clinical trial;
  c) Such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and
  d) The patient is a suitable candidate for the transplant under the medical protocols used by the Plan.

- **Drugs:** Any drug which has been approved by the FDA, provided that it:
  a) Conforms to FDA approved use guidelines, or
  b) Conforms to usage listed in one of the Recognized National Compendia.

**Extended Care Facility:** An institution (or part of an institution) that is licensed to provide convalescent or skilled nursing care to resident patients and that is or could be certified as a skilled nursing facility under Medicare.

Extended care facility benefits are restored for each new period of confinement. A new period of confinement begins at least 60 days after the last confinement. To be covered for extended care facility benefits, admission to the skilled nursing facility must be for non-routine care at the recommendation and under the supervision of a physician.
**Home Health Care:** Part-time intermittent care by or under the supervision of a registered nurse (RN) or licensed practical nurse (LPN) other than a member or resident of the household, including:

- Visits by persons who have completed a home health aide training course under the supervision of a registered nurse, up to four hours per visit;
- Physical therapy, occupational therapy and speech therapy, provided by a licensed therapist;
- Medical supplies and equipment prescribed by a physician, and laboratory services to the extent such items would have been covered if such covered person had been hospitalized;
- A physician’s home visit or office visits or both;
- Nutritional consultation; or
- Medical social work.

Each visit by an employee of a home health agency or four hours of home health aide service shall be considered as one home health care visit.

**Exclusions and limitations for home health care:**

**In no event shall home health care expenses include charges for:**

- Services solely for custodial care;
- Transportation services;
- Any period during which the covered person is not under the continuing care of a physician;
- Injury or sickness arising out of or in the course of employment, or which is compensable under any Workers’ Compensation or Occupational Disease Act or law; or
- Declared or undeclared war or act of war.

**Hospice Care:** If a covered person is terminally ill with a life expectancy of six months or less, covered expenses include charges of an approved hospice agency for medically necessary hospice care.

Hospice benefits are subject to the following provisions:

- The patient’s physician must establish and review, at least once in each three months, a written treatment plan that describes the hospice care to be provided. The Plan may require a copy of this treatment plan.
- All services and care must be included in the treatment plan, and the covered hospice expenses are limited to the following: Covered services for hospice care are the same as those for home health care (see Home Health Care above).

**Hospital:** A general hospital shall be an institution that meets all of the following requirements. It:

- Is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment, and care of injured or sick persons;
- Has organized departments of medicine and surgery;
- Has a requirement that every patient must be under the care of a physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered graduate nurse (RN);
- Is duly licensed by the agency responsible for licensing such hospitals, if licensing is required;
- Is not, other than incidentally, a place of rest; a place primarily for the treatment of tuberculosis or mental or emotional disorders; a place for the aged, drug addicts or alcoholics; or a place for custodial care; and
- Is accredited by the American Hospital Association.

Services rendered in the infirmary or clinic of a college, university or private boarding school shall be eligible expenses. In such instances, if a covered person is confined in a school facility that does not meet the definition of a hospital because it has no operating room, benefits may be paid, provided the charges for such confinement do not exceed the reasonable and customary charges for the disability involved.

**Illness:** Sickness or disease that causes loss covered by the Plan. Losses incurred by a covered person because of pregnancy, childbirth and related medical conditions are covered under the Plan to the same extent as any illness.

**Injury:** Bodily harm by an outside force that results from an accident and results in a loss covered by the Plan.

**Inpatient:** Hospital confinement for which a room and board charge is made.
**Intensive Care Unit:** An accommodation or part of a hospital other than a postoperative recovery room which, in addition to providing room and board is:
- Established by the hospital for a formal intensive care program;
- Exclusively reserved for critically ill patients requiring constant audiovisual observation prescribed by a physician and performed by a physician or by a specially trained registered nurse; and
- Provides all necessary lifesaving equipment, drugs and supplies in the immediate vicinity on a standby basis.

**Maximum Benefit:** The maximum amount the Plan will pay over the course of your own or your covered dependent’s lifetime, regardless of whether your coverage is continuous.

**Medical Devices:** Any medical device provided that it:
- Has been approved by the FDA, and
- Conforms to approved use guidelines.

**Medical Emergency:** The sudden and unexpected onset of a condition with severe symptoms, which, if not treated immediately, may result in serious medical complications, loss of life or permanent impairment of bodily functions. Medical emergencies include, but are not limited to, heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration convulsions.

**Medical Necessity:** All covered services, except routine circumcision, voluntary sterilization procedures, transplant donor suitability testing and preventive health services, must be medically necessary and appropriate for the member’s specific health care needs. This means that all covered services must be consistent with generally accepted principles of professional medical practice. Blue Cross Blue Shield decides which covered services are medically necessary and appropriate for the participant by using the following guidelines. All health care services must be required to diagnose or treat the patient’s illness, injury, symptom, complaint or condition and they must also be:
- Consistent with the diagnosis and treatment of the patient’s condition and in accordance with Blue Cross Blue Shield medical policy and medical technology assessment guidelines.
- Essential to improve the patient’s net health outcome and as beneficial as any established alternatives covered by this group Health Plan. (This means that if Blue Cross Blue Shield determines that the patient’s treatment is more costly than an alternative treatment, benefits are provided for the amount that would have been provided for the least expensive alternative treatment that meets the patient’s needs. In this case, the patient must pay the difference between the claim payment and the actual charge.)
- As cost-effective as any established alternatives and consistent with the level of skilled services that are furnished.
- Furnished in the least intensive type of medical care setting required by the patient’s medical condition.

A *medically necessary* service is not a service that: is furnished solely for the patient’s convenience or religious preference or the convenience of the patient’s family or health care provider; promotes athletic achievements or a desired lifestyle; improves the patient’s appearance or how the patient feels about his or her appearance; or increases or enhances the patient’s environmental or personal comfort.

**Medicare:** The programs established by Title I of Public Law 89-98 (70 Statutes 291) as amended, titled “Health Insurance for the Aged Act,” which includes Parts A and B and Title XVIII of the Social Security Act (as amended by Public Law 89-07-79) as amended from time to time.

**Mental Hospital:** An institution (other than a hospital as defined) which specializes in the diagnosis and treatment of mental illness or functional nervous disorders which is operated pursuant to law and meets all of the following requirements. It:
- Is licensed to give medical treatment;
- Is operated under the supervision of a physician;
- Offers nursing service by a registered graduate nurse (RN) or licensed practical nurse (LPN);
- Provides, on the premises, all the necessary facilities for medical treatment; and
- Is not, other than incidentally, a place of rest; a place for the aged, drug addicts or alcoholics; or a place for convalescent, custodial or educational care.
**Mental Illness:** Neuroses, psychoneuroses, psychopathies, psychoses, and other mental and emotional disorders.

**Non-Contributory Coverage:** Group plan benefits for which the covered employee enrolls and for which he or she is not required to make a contribution toward the cost of coverage.

**Non-Covered employees:** Notwithstanding the above, a covered employee shall immediately cease being a covered employee for purposes of determining eligibility under these provisions if he or she becomes employed by an employer who is not required to make contributions to the Plan in a category of employment that otherwise would be considered Covered Employment, except that a covered employee who is working for an employer that is not required to make contributions to the Plan at the request of and with the permission of the Union for the purpose of causing the employer to become a contributing employer, remains a covered employee.

A non-covered employee also includes an apprentice in the Hoisting and Portable Engineers Local 4 Apprenticeship and Training Program who is dismissed from the program. An apprentice who is dismissed from the program is not a covered employee as of the date of termination.

**Non-Covered Employment:** Employment in a category of work covered by a collective bargaining agreement or a Participation Agreement for which the employer is not required to make contributions to the Plan on behalf of the employee.

**Nursing Services:** Skilled services which are furnished by or under the direct supervision of skilled personnel to ensure the safety of the patient and achieve the medically desired result and for which the planning and management of a treatment plan requires the continuing involvement of a licensed nurse.

**Office Employee:** An employee of the Union, the IUOE Local 4 Annuity Fund, the IUOE Local 4 Apprenticeship and Training Fund, the IUOE Local 4 Health and Welfare Fund, the IUOE Local 4 Annuity and Savings Fund, or the IUOE Local 4 Pension Fund for whom contributions are agreed to be made by the Union or the respective Fund.

**Office employer:** The International Union of Operating Engineers, Local 4; the International Union of Operating Engineers, Local 4 Hoisting and Portable Engineers Apprenticeship and Training Program; or the International Union of Operating Engineers, Local 4 Health and Welfare, Pension, and Annuity and Savings Funds.

**Other Hospital Charges:** Any charges, other than charges for room and board, made by a hospital on its own behalf for necessary medical services and supplies actually administered during hospital confinement or as an outpatient in a hospital. Necessary services and supplies also include any charges, regardless of who makes them, for the administration of anesthetics during hospital confinement, but will not include any charges for special nursing fees, dental fees or medical fees from physicians not on the hospital staff.

**Out-of-Pocket Maximum:** The Plan limits the amount of eligible, unreimbursed medical expenses you pay in any calendar year. This is called your “out-of-pocket maximum.” After a covered individual or family member reaches the out-of-pocket maximum, the Plan pays 100% of covered expenses for the rest of the calendar year for that person or any covered family member if network providers are used. Benefits increase to 80% (from the out-of-network benefit level) if out-of-network providers are used, unless services are related to a medical emergency admission or emergency room care, in which case the services will be covered at 100%. The out-of-pocket maximum includes your eligible coinsurance amounts and your deductible. It does not include:

- Office visit co-pays;
- Charges in excess of reasonable and customary;
- Penalties and reductions in benefits due to noncompliance with the Plan’s utilization management protocols;
- Durable medical equipment or other services limited by separate maximums; and
- Expenses the Plan does not cover.

**Outpatient:** Any hospital expense incurred for which no room and board charge is made.
**Participant**: An eligible covered employee or eligible dependent.

**Participation Agreement**: An agreement between the Plan and an employer under which the employer is obligated to make contributions to the Plan.

**Pediatric Care**: Care provided to an individual through age 18, or less than 19 years of age.

**Pharmacy**: A licensed establishment where prescription drugs are dispensed by a licensed pharmacist.

**Pre-Existing Condition**: An injury, illness, or any condition related to that injury or illness for which an employee or family member received diagnosis, advice or treatment, or incurred expenses within three months before the effective date of coverage.

**Provider**: Covered providers include: doctors of medicine (MD); doctors of osteopathy (DO); dentists (DMD or DDS); psychologists (EdD or PhD); podiatrists (DPM); chiropractors (DC); optometrists (OD); social workers (LICSW); advance registered nurse practitioners (NP), who are covered to the extent nurses are supervised by doctors of medicine (MD) and are acting within the scope of their license; physician’s assistants (PA); and other health professionals licensed by the state in which services are being rendered and acting within the scope of their license.

**Psychologist**: An individual who is duly licensed or certified as a psychologist in those jurisdictions where statutory or non-statutory licensure or certification exists or, in those jurisdictions where neither exists, an individual who is duly qualified as a professional psychologist by a recognized psychological association.

**Registered Nurse**: An individual who has received specialized nursing training and is authorized to use the designation of RN and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

**Rehabilitative Care**: Necessary inpatient medical care (as prescribed by a physician) rendered in a rehabilitation hospital (as defined herein) other than the surgical facilities requirement and, in addition, that meets the following criteria. It must:
- Be accredited by the Joint Commission on Accreditation of Healthcare Organizations and be approved for federal Medicare benefits as a qualified hospital;
- Maintain transfer agreements with acute care facilities to handle surgical and/or medical emergencies; and
- Maintain a utilization review committee.

**Reimbursement**: If you or your dependent are injured and recover damages from a third party, an insurance company or any other party, then you must reimburse the Plan for payments it has made or will make in connection with the injury. Upon receipt by you or your dependent or your legal representative, the monies recovered as a result of judgment, settlement or any other cause related to the injury shall become an asset of the Plan, and shall be held in trust for the Plan. By accepting benefits from the Plan, you or your dependent agrees that any amounts recovered by judgment, settlement or compromise will be applied first to reimburse the Fund for 100% of benefits paid, without reduction or set-off for attorney’s fees, regardless of whether you or your dependent are made whole. These Plan assets may not be distributed without a release from the Plan. The Plan is not required to participate in your or your dependent’s claims to demand reimbursement from any person or to invoke its subrogation rights. However, the Plan, at its sole discretion and election, may request that you or your dependent assign or subrogate your claims or any other right of recovery to the Plan so that the Plan can enforce its right to recovery.

**Social Worker**: An individual who is duly licensed and holding a master’s degree in social work from a university approved by the National Association of Social Workers (NASW).
**Special Care Facility:** An institution which is not a hospital as defined, but which specializes in physical rehabilitation of injured or sick patients or the diagnosis and treatment of mental illness or nervous disorders, or which qualifies as an extended care facility and a provider of services under Medicare, but only if that institution is constituted, licensed and operated in accordance with the laws of legally authorized agencies responsible for medical institutions.

**Spouse:** An individual to whom you are legally married under the laws of the state where the marriage occurred.

**Subrogation:** The Plan’s right to be substituted in place of you or your eligible dependent with reference to a lawful claim or right that you or your dependent have against a third party (such as another person or organization, including your own automobile insurer) who may have caused injury or illness that resulted in the Plan’s payment of benefits. In the event of the Plan’s payment for any benefits as a result of an illness or injury, the Plan shall, to the extent of such payment, be subrogated to all rights of recovery of you or your dependent, and shall be entitled to immediate payment of amounts due before any distribution to you or your dependent, or on your behalf.

**Total Disability:** An employee is considered totally disabled if, as a result of an illness or accidental injury, the individual is unable to engage in any gainful occupation for which he or she is reasonably fitted by education, training or experience and is not performing work of any kind for wage or profit. A covered dependent is considered totally disabled if, because of an illness or an accidental injury, he or she is prevented from engaging in all the normal activities of a person of like age and sex who is in good health.

**Union:** International Union of Operating Engineers, Local 4 and its branches.
SECTION VII: Privacy and Administrative Information

Your Privacy Rights Under HIPAA

The federal Health Insurance Portability and Accountability Act (HIPAA) requires that health plans protect the confidentiality and privacy of your health information. A description of your rights under HIPAA can be found in the Plan’s Privacy Notice which follows and is available on request from the Funds Office.

NOTICE OF PRIVACY PRACTICES

IUOE LOCAL 4 HEALTH AND WELFARE FUND

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This policy is effective September 20, 2013

If you have any questions about this notice, please contact IUOE LOCAL 4 HEALTH AND WELFARE FUND PRIVACY OFFICER, 16 Trotter Drive, P.O. Box 660, Medway, MA 02053, 1-508-533-1400 or 1-888-486-3524.

The federal Health Insurance Portability and Accountability Act (HIPAA) requires the Local 4 Health and Welfare Fund (“the Fund” or “We”) to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your Protected Health Information. The Fund must abide by the terms of the Notice currently in effect.

The Fund must maintain the privacy of any information it creates or receives that can be identified as yours as it:

- Relates to payment of health care for you, or
- Pertains to your physical or mental health condition.

Identifiable information refers to health information that

- Is explicitly linked to you, and also
- Has enough data included that allows for individual identification.

This is referred to as Protected Health Information or PHI for short.

The Fund is legally obligated to abide by the terms of the current Notice and to let you know when and under what circumstances it needs your authorization to use PHI and when or under what circumstances it does not need your authorization to use PHI. The Fund must also describe such uses in plain terms.

The purpose of this Notice is to provide you with this information and to notify you of your rights under HIPAA. The Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that it maintains. A revised Notice will be provided to covered individuals as required by HIPAA when the Fund makes a material change or revision to the contents of this Notice.

Local 4 Health and Welfare Fund does not need your authorization to use and disclose PHI for the purposes of payment, treatment or health care operations.

Some examples of how the Fund may use and disclose your PHI for these purposes are provided below:

**Treatment:**
To process claim payments submitted to us for treatment rendered to you by a provider or to issue an explanation of benefits statement to you for you or anyone in your family. (Upon written request, the Plan Privacy Officer will distribute explanation of benefits forms addressed only to the participant or dependent.)

**Payment:**
For paying medical, dental or vision claims for you and your dependents, and for utilization review or management of such claims.
**Health Care Operations:**

- To coordinate or manage your health care, including to coordinate benefits with another insurance program that also provides you with coverage, such as an automobile insurance carrier;
- For related administrative purposes, such as obtaining or renewing stop loss coverage, or for underwriting, premium rating, and other activities related to the creation or renewal of a contract for insurance (though the Fund will not disclose PHI that is genetic for underwriting purposes);
- To communicate with other providers of insurance benefits, such as the prescription drug program;
- To identify groups of people with similar health problems to give them information about treatment alternatives or educational programs, such as disease management programs;
- To comply with administrative requirements such as providing PHI as necessary to accountants and lawyers to enable them to provide accounting and legal services to the Fund;
- To disclose PHI to the sponsor of the Plan (Board of Trustees), such as for processing an appeal of a denial of benefits or coverage.

**In addition, the Local 4 Health and Welfare Fund does not need your authorization to use or disclose PHI:**

- To comply with local, state or federal law, or for health care oversight activities authorized by law, as for example, when a disclosure is required by subpoena or to comply with a governmental health oversight board investigating complaints against physicians or other health care providers;
- For public health activities, which generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; or reduce the risk for contracting or spreading a disease or condition;
- For research under certain circumstances, including to study treatment outcomes, costs and benefit design, after we remove information that personally identifies you;
- When the disclosure relates to victims of abuse, neglect or domestic violence;
- For law enforcement purposes, including to respond to a subpoena, warrant, summons or similar process, or in some cases to identify or locate a suspect or report a crime;
- For specialized governmental functions, such as to disclose an individual’s PHI to authorized federal officials for the conduct of national security or intelligence-related activities authorized by law, including providing protection to the president or other authorized persons or foreign heads of state;
- For the duties of a coroner, medical examiner or funeral director, to identify the body of a deceased person, to determine a cause of death or to perform other authorized duties;
- For facilitating organ donation and transplants, including release of necessary medical data to organizations engaged in the procuring, banking, or transplanting of human organs, eyes, or tissue;
- To comply with Workers’ Compensation laws or other similar programs to the extent necessary;
- To avert a serious threat to health or safety or to prevent or lessen an imminent threat to the health and safety of another person or the public;
- For judicial proceedings, such as in response to a court order, subpoena or other lawful process, after the Fund is assured efforts have been made to notify you of the request or to obtain an order protecting the information requested;
- To business associates acting on the Fund’s behalf and providing services (such as legal, auditing and claims utilization review) to the Fund. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract with them;
- To provide legally required notices of unauthorized access to or disclosure of your health information; if the Fund experiences a breach of unsecured PHI, it will notify affected individuals within 60 days of discovery and will also notify the U.S. Department of Health and Human Services and local media outlets if the breach affects 500 or more individuals;
- To the correctional institution or law enforcement official if you are an inmate of a correctional institution or under the custody of a law enforcement official, if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
We may also make other uses and disclosures, which occur as a by-product of these permitted uses and disclosures of PHI.

Local 4 Health and Welfare Fund must have your written authorization to disclose PHI for any other purpose, including disclosure of PHI relating to your health and welfare claims, to someone other than you. You may revoke such an authorization at any time in writing.

The types of uses and disclosures that require your authorization include:
- The use and disclosure of psychotherapy notes, except by the originator of the notes for treatment, by the Fund for its own supervised training programs, or by the Fund to defend itself in a legal proceeding;
- The use and disclosure of PHI for marketing, except if the communication is in the form of a face-to-face communication by the Fund to an individual or a promotional gift of nominal value by the Fund; and
- The disclosure of PHI that is a sale of PHI as defined by HIPAA regulations.

The uses and disclosures that require us to give you an opportunity to object and opt:
- Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

You have individual rights with respect to PHI. You have the right to:
- An accounting of certain disclosures of PHI, including disclosures we have made of your PHI other than for treatment, payment or health care operations. You must submit your request in writing.
- Inspect and copy your PHI. You must put your request in writing. The Fund has up to 30 days to make the information available to you, and may charge a reasonable fee for the cost of copies, mailing or supplies associated with your request. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or, if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
- Amend your PHI in certain circumstances with certain limitations, such as if you believe PHI about you is incorrect or incomplete. You must put your request in writing and give a reason.
- Revoke your authorization to disclose PHI at any time in writing.
- Request reasonable confidential communications of PHI by alternative means or to alternative locations (for example, your workplace). We may ask that you put such a request in writing, but we may not require an explanation of the reason for the request.
- Request certain restrictions of use and disclosures of PHI. While you have the right to request a restriction on the Fund’s use and disclosure of your PHI, the Fund is not required to agree to a restriction. The Fund will agree to your request for restriction, however, if the disclosure is for payment or health care operations purposes and the PHI pertains solely to a health care item or service for which you have paid the Fund out of pocket in full.

You also have additional rights:
- You have the right to a paper copy of this Notice upon request.
- You may file a complaint about our privacy practices by contacting the Privacy Officer at the address listed in this Notice. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. You may not be penalized or retaliated against for filing such a complaint.
Providing PHI to the Board of Trustees (Plan Sponsor)

Permitted Disclosures of PHI

Unless otherwise permitted or required by law, and subject to obtaining written certification described below, on and after the date this Plan is required to comply with the provisions governing the use and disclosure of PHI pursuant to the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, the portions of the Plan that qualify as a Health Plan as defined in 45 CFR §160.103 (or a health insurance issuer or HMO with respect to such Health Plan) may disclose PHI (as defined in 45 CFR §160.103) to the Plan Sponsor only for the purpose of enabling the Plan Sponsor to perform administrative functions related to the treatment, payment and health care operations of such Health Plan as defined in 45 CFR §164.501.

In no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

Conditions of Disclosure

The Board of Trustees (Plan Sponsor) agrees that with respect to any PHI disclosed to it by a Health Plan (or a health insurance issuer or HMO with respect to the Plan,) it shall:

- Not use or further disclose the PHI other than as permitted or required by the Health Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from a health plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to a health plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available PHI in accordance with HIPAA’s access requirements in accordance with 45 CFR §164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from a health plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Plan with subpart E of 45 CFR §164;
- If feasible, return or destroy all PHI received from a health plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, it shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation between a health plan and plan sponsor, required in 45 CFR §504(f)(2)(iii), is satisfied.

To satisfy the requirements set forth above, the following conditions shall apply:

- Only Trustees and employees who are on the staff of the Claims Office shall be given access to the PHI to be disclosed;
- The access to and use of PHI by the individuals described in the preceding sentence shall be restricted to the Plan administration functions that the Plan Sponsor performs for a health plan; and
- If a Trustee or employee who is on the staff of the Funds Office fails to comply with the provisions of the Plan Document relating to the use and disclosure of PHI, he or she shall be subject to disciplinary action under the Plan Sponsor’s established policies and procedures.

Certification by Plan Sponsor

A health plan (or a health insurance issuer or HMO with respect to such health plan) shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan Document has been amended to incorporate the provisions of 45 CFR §164.504(f)(2(ii), and that the Plan Sponsor agrees to the conditions of the disclosure set forth above in the section titled “Conditions of Disclosure.” A health plan shall not disclose and may not permit a health insurance issuer or HMO to disclose PHI to the Plan Sponsor as otherwise permitted herein unless the statement required by 45 CFR §164.520(b)(1)(iii)(C) is included in the appropriate notice.
Your Privacy and the Internet

Permitted Disclosures of PHI
In the Information Age, special care must be taken to ensure that your personal health care information remains private. The Trustees of the IUOE Local 4 Health and Welfare Fund (Fund) are committed to safeguarding participants’ privacy by providing protection against unauthorized access or use of confidential information.

The Fund maintains administrative, physical and technical safeguards that comply with the HIPAA guidelines. To protect your personal information against unauthorized access or use, our employees are subject to a code of ethics and other policies that require them to maintain the confidentiality of protected health information. The Fund will continue to enhance and maintain prudent security standards and procedures to protect your personal information.

New federal laws have been passed to ensure the safety of your information. The following is a summary of the requirements and the Trustees’ pledge to uphold these standards.

The Trustees shall, in accordance with the Security Regulations:
• Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan.
• Ensure that “adequate separation” is supported by reasonable and appropriate security measures. “Adequate separation” means the Plan Sponsor will use ePHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in violation of the Plan’s security or privacy policies and procedures or this Plan provision shall be subject to the Plan’s disciplinary procedure.
• Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.
• Report to the Plan any security incident of which it becomes aware.

The Trustees and the Plan will do their best to protect your ePHI, but we must ask for your help as well.

Although the Fund has taken measures to safeguard private information once it reaches the Fund, it cannot be responsible for the content of emails sent to the website or to the Fund. The Fund cannot protect emails sent to this website from being intercepted by others and decrypted during transmission. For this reason, the Fund requests that all participants and providers who do not have a business associate agreement with the Fund refrain from sending any private, health or otherwise confidential information to the Fund through the website or by email.
## Plan Administrative Information

**Plan employer Identification Number:** 04-6040880  
**Plan Number:** 501

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Dental Plan</th>
<th>Prescription Drug Plan</th>
<th>Vision Plan</th>
<th>Hearing Plan</th>
<th>Life Insurance</th>
<th>AD&amp;D</th>
<th>Loss of Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care plan, Medical</td>
<td>Dental plan</td>
<td>Health care plan, Prescription</td>
<td>Health care plan, Vision</td>
<td>Health care plan, Hearing</td>
<td>Life insurance plan</td>
<td>Accidental death and dismemberment plan</td>
<td>Health care plan, Disability</td>
</tr>
<tr>
<td>Type of Administration</td>
<td>Contract administrator</td>
<td>Contract administrator</td>
<td>Contract administrator</td>
<td>Trust fund, self administered</td>
<td>Contract administrator</td>
<td>Contract administrator</td>
<td>Trust fund, self administered</td>
</tr>
<tr>
<td>Funding Method</td>
<td>Self-insured</td>
<td>Self-insured</td>
<td>Self-insured</td>
<td>Self-insured</td>
<td>Self-insured</td>
<td>Fully insured</td>
<td>Fully insured</td>
</tr>
</tbody>
</table>
| Claims Administrator for the Plan | Blue Cross Blue Shield of Massachusetts  
Landmark Center  
401 Park Drive  
Boston, MA 02215-3326  
1-800-401-7690 | Delta Dental of MA  
465 Medford  
Street  
Boston, MA 02129  
1-800-451-1249 | CVS/Caremark, Inc.  
2211 Sanders Road  
Northbrook, IL 60062  
1-800-323-8083 | Davis Vision Vision Care Processing Unit  
P.O. Box 971  
Schenectady, NY 12301  
1-800-999-5431 | EPIC Hearing Health  
17870 Castleton Street  
City of Industry, CA 91748  
1-866-956-5480 | AIG  
P.O. Box 1580  
Neptune, NJ 07754-1581  
1-800-250-8898 | AIG  
P.O. Box 1580  
Neptune, NJ 07754-1581  
1-800-250-8898 | International Union of Operating Engineers, Local 4 Health and Welfare Fund  
16 Trotter Drive  
P.O. Box 660  
Medway, MA 02053  
1-508-533-1400 or 1-888-486-3524 |
Plan Trustees
The Plan is funded through a separate trust established to make benefit payments according to the terms of the Plan.

<table>
<thead>
<tr>
<th>Union Trustees</th>
<th>Employer Trustees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louis G. Rasetta, Chairman</td>
<td>John J. Shaughnessy, Jr.</td>
</tr>
<tr>
<td>International Union of Operating Engineers, Local 4</td>
<td>Shaughnessy &amp; Ahern Company</td>
</tr>
<tr>
<td>16 Trotter Drive</td>
<td>346 D Street</td>
</tr>
<tr>
<td>Medway, MA 02053-2299</td>
<td>South Boston, MA 02109</td>
</tr>
<tr>
<td>David F. Fantini</td>
<td>James Reger</td>
</tr>
<tr>
<td>International Union of Operating Engineers, Local 4</td>
<td>Mass. Aggregate and Asphalt Pavement Association</td>
</tr>
<tr>
<td>16 Trotter Drive</td>
<td>1500 Providence Highway, Suite 14</td>
</tr>
<tr>
<td>Medway, MA 02053-2299</td>
<td>Norwood, MA 02062</td>
</tr>
<tr>
<td>Paul C. DiMinico</td>
<td>Nino Catalano</td>
</tr>
<tr>
<td>International Union of Operating Engineers, Local 4</td>
<td>East Coast Slurry Company</td>
</tr>
<tr>
<td>16 Trotter Drive</td>
<td>145 Island Street</td>
</tr>
<tr>
<td>Medway, MA 02053-2299</td>
<td>Stoughton, MA 02072</td>
</tr>
</tbody>
</table>

Plan Year
The Plan is administered on a calendar-year basis from January 1 to December 31.

Agent for Service of Legal Process
If for any reason you wish to seek legal action, you may serve legal process upon:

Board of Trustees
International Union of Operating Engineers
Local 4 Health and Welfare Fund
16 Trotter Drive
P.O. Box 660
Medway, MA 02053
1-508-533-1400 or 1-888-486-3524

You also may serve legal process upon any of the individual Plan trustees listed.

Authority
The Trustees have authority to control and manage the administration of this Plan and to delegate such authority as permitted by the terms of the Trust, the Plan and ERISA. The Trustees shall be the named fiduciary of the Plan, and possess the specific powers, duties, and responsibilities set forth under the Trust, the Plan and ERISA.

Rights and Duties
The Trustees shall administer and interpret the Plan and have been granted the sole and absolute discretionary power to take all action and to make all decisions necessary or proper to carry out the terms of the Plan. The determination of the Trustees as to any questions of fact, any questions involving the administration and interpretation of the Plan, and any questions regarding rights to benefits under the Plan shall be conclusive as to all parties to the Plan and their determination shall not be overturned unless said determination is arbitrary and capricious.
For life insurance, the fiduciary is AIG Life Insurance Company; for AD&D Insurance, the fiduciary is AIG Life Insurance Company. This means that for these benefits, the insurance companies have sole authority to make claim and eligibility determinations. All such determinations and decisions will be final and conclusive on all parties and will not be overturned unless such determinations, actions and/or decisions are arbitrary and capricious.

No local union officer, business agent, local union employee, employer or employer representative, Funds Office personnel, consultant, attorney, agent of Blue Cross Blue Shield, or any other person is authorized to speak for or on behalf of the Trustees, or to commit the Trustees of this Fund on any matter relating to the Fund without the express authority of the Trustees.

**Future of the Plan**
Although the Board of Trustees has no present intention to terminate the Plan, it has expressly retained the right to amend, modify or terminate the Plan at any time.

Any such action of the Board of Trustees will be evidenced by a written amendment which is filed with the Plan Documents and communicated to Plan participants in the manner required by law.

If the Plan is terminated, available assets will be distributed to participants and beneficiaries according to the Trust Agreement and ERISA.

**Missing Participant**
Any benefit payable under this Plan shall be forfeited if the Trustees, after a reasonable effort, are unable to locate the participant, eligible employee, dependent or other individual to whom payment is due on a benefit claim timely filed with the Trustees.

However, any forfeited benefit payment shall be reinstated if a claim is made for such payment by such individual, or if the individual has died, his or her designated beneficiary or his or her estate, within the applicable time period described in the Plan.

**Physical or Other Disability**
If the Plan Administrator finds that any person to whom an amount is payable under the Plan is unable to care for his affairs because of illness or accident, or is a minor, or has died, then any payment due him or her or his estate (unless a prior claim therefore has been made by a duly appointed legal representative) may be paid to his or her designated beneficiary, an institution maintaining or having custody of such person, his estate, or any other person deemed by the Plan Administrator to be a proper recipient on behalf of such person otherwise entitled to payment. Any such payment shall be a complete discharge of the liability of the Plan Administrator and Plan.

**Transmittal of Notices**
All notices, statements, reports and other communications from the Plan Administrator required or permitted under the Plan shall be deemed to have been given when delivered to the participant, or mailed to the participant at the address last appearing on the records of the Plan Administrator.

**Controlling Law**
To the extent not preempted by federal law and regulation, this Plan and all rights thereunder shall be governed by and construed in accordance with the laws of the Commonwealth of Massachusetts.

**Vested Rights**
No person, covered employee or dependent shall have any vested rights under the Plan and/or insurance contract(s).

**Spendthrift**
As, and to the extent required by ERISA and the Code, any benefits and interest in the Plan and/or insurance contract(s) shall not be anticipated, assigned, alienated, or subject to attachment, garnishment, levy, execution, or other legal or equitable process, or otherwise be subject to the claims of third-party creditors, except as provided under the terms of a Qualified Medical Child Support Order, and provided further that nothing in this provision shall prevent the Trustees, the Trustees of the International Union of Operating Engineers, Local 4 Pension Fund, or the International Union of Operating Engineers, Local 4 Annuity and Savings Plan from making a claim for offset against any benefit or interest in the Plan and/or insurance contracts.
Information From Participants
Each covered employee, dependent or beneficiary shall furnish the Plan Administrator in the form prescribed by it and at its request, such personal data, affidavits, consents, authorizations to obtain information, or other information as the Plan Administrator deems necessary or desirable for the administration of the Plan.

Examinations
The Board of Trustees of the Plan has the right, through its medical representatives, to request an independent medical exam when and so often as it may reasonably require to audit or adjudicate any claim filed under the Health and Welfare Plan.

Fraud and Abuse Policy
This Plan is subject to federal laws which provide that criminal penalties may be imposed against those who receive or attempt to receive health care plan benefits by committing fraud or abuse against the Plan. State fraud and abuse laws may also apply.

In addition, the Plan may bring a lawsuit against any participant, beneficiary or provider who obtains services or payments to which he or she is not entitled. The Plan may also offset future benefit payments otherwise due to a participant or beneficiary or a future reimbursement to a medical provider.

Any person who commits a fraudulent act against the Plan may be subject to criminal prosecution, fine or imprisonment as provided by law. The following items listed may be considered fraud against or abuse of the Plan:
1. Falsifying, withholding, omitting or concealing information to obtain coverage or payment for services;
2. Misrepresenting eligibility criteria for Dependents (for example, marital status, age, dependent child status) to obtain or continue coverage for a person who would not otherwise meet the dependent eligibility criteria, as defined in the Plan, and qualify for coverage;
3. Withholding, omitting, concealing or failing to disclose any medical history or health status where required;

4. Making or using any false writing or document in connection with obtaining coverage or payment for health benefits, including falsifying or altering (a) a Certificate of Creditable Coverage, (b) a claim form or (c) medical records;
5. Permitting a person who is not covered under the Plan to use a Plan identification card or other Plan identifying information to obtain covered services or payment under this Plan;
6. Making false or fraudulent representations in connection with delivery of or payment for health benefits, or being untruthful to obtain payment or reimbursement under this Plan; or
7. Obtaining, or attempting to obtain, medical care or Covered Services under this Plan under false or fraudulent pretenses.

Guidelines Concerning Participation in the IUOE Local 4 Benefit Funds of a Sole Proprietor, Partner, Corporate Stockholder, Corporate Officer and/or Their Relatives

A. Definitions
Federal law requires that the Trust Funds be for the sole and exclusive benefit of the employees. Effective January 1, 2010, for purposes of participation in these Funds, an individual will be considered to be an employee and must participate in the Funds if he or she is employed by an employer for wages under a Collective Bargaining Agreement which requires contributions to be made to the Funds on his or her behalf, and/or is employed by the employer for wages and the employer has executed a Participation Agreement which requires contributions to be made to the Funds on his or her behalf.

Certain categories of persons who have an ownership interest in an employer or who have a special relationship with an employer may be considered employees for purposes of participation in the Trust Funds. If such persons participate in the Funds, the employers of persons in these categories must contribute to the Funds in accordance with the rules. If such persons are non-collectively bargained Employees, their
employers must comply with additional rules. The categories subject to
these rules are:

- A person who has an ownership interest in an incorporated employer
  (hereafter referred to as “Owner” or “Stockholder”).
- A person who is an officer of or is otherwise involved in the management of
  an incorporated employer (hereafter referred to as an “Officer”).
- A person who is a relative—that is, a child, stepchild, spouse, parent,
  brother, sister, son-in-law, father-in-law or other relative as determined
  by the Trustees in specific cases—of a Stockholder or an Officer, or a Sole
  Proprietor or Partner of an unincorporated employer (hereafter referred to
  as a “Relative”).

B. Rules on Initial, Continuing, and Termination of Eligibility for Officers,
Stockholders and Their Relatives

1. Eligibility to Participate

- An Owner or an Officer or Relative who works in Covered
  Employment will be initially eligible to participate in the IUOE Local
  4 Benefit Funds under the same terms as employees performing
  Covered Employment under the Collective Bargaining Agreement.
- A Sole Proprietor or Partner in an unincorporated business is an
  employer by law and may not participate in the Trust Funds.
  However, his or her employees who are covered by the Collective
  Bargaining Agreement must be reported to the Trust Funds and
  contributions must be made to the Funds on behalf of these
  employees as required by the Collective Bargaining Agreement.

An employee who is married to one of the Owners of an
unincorporated business and who files a joint federal tax return
with that spouse that includes the operation of the business may
not participate in the Trust Funds. All other Relatives of Sole
Proprietors or Partners of unincorporated businesses are subject
to these guidelines.

2. Conditions of Eligibility to Participate for Officers, Stockholders or
Their Relatives

- The employer of an Officer, Stockholder or Relative as defined above
  who is or will be participating in the Funds must, as a condition for
  participation, sign a Participation Agreement and must agree to
  maintain records for at least seven years—the current year plus the
  prior six years—to document the total hours worked by each Officer,
  Stockholder or Relative, a description of the type of work performed
  and the amount of each type of work, including the total hours of
  work in Covered Employment.
- The employer of an Officer, Stockholder or Relative as defined
  above, who is participating in the Funds, must contribute to all of
  the Funds to which contributions are required for collectively bargained
  employees under the applicable collective bargaining agreement.
- The Owner of an unincorporated business, whose spouse is an
  Employee participating in the Funds, must annually submit the
  separate tax returns filed by the Owner and his or her Employee
  spouse.
- If an erroneous overpayment is made to the Funds, the Trustees, in
  their discretion, may decide whether to retain the contributions, or
  whether to refund the contributions, after the deduction of the costs
  of correcting the error and the deduction of benefit payments made
  based on the erroneous overpayment.

C. Amount of Contributions; Payment of Contributions

Contributions for Owners and Officers must be made at the rate of 150
hours per month at the hourly rate set forth in the Collective Bargaining
Agreement or the Participation Agreement between the employer and
the Benefit Funds. All remittance reports and contributions are due in the
Funds Office no later than the 19th day of each calendar month for
the following month’s coverage.

D. Participation Agreement; Governing Law

In order for an Owner or Officer to participate in IUOE Local 4 Benefit
Funds, the employer must execute the Participation Agreement in a form
acceptable to the Funds. Participating employers must also meet
applicable IRC regulatory requirements.
Information Compliance

Individuals covered under the Health and Welfare Plan are required to furnish the Plan Administrator, in the manner prescribed by the Plan Administrator and at his or her request, information that the Plan Administrator deems necessary or desirable to administer the Plan. This includes:

- Personal data;
- Affidavits;
- Consents;
- Authorizations to obtain information; or
- Other information.

The most important provisions have been generally described in this document. You are not entitled to benefits under the Plan unless you meet all of the detailed requirements spelled out in the Plan. You must apply for benefits in order to receive any payments from the Plan as described in this document.

Also, you should be sure to keep the Plan Administrator informed of any changes in your address, because benefits cannot be paid to you if you cannot be located.

Summary Plan Description and Plan Document

This booklet is intended to satisfy the requirements of a Summary Plan Description (SPD), and a Plan Document, as specified in the Employee Retirement Income Security Act (ERISA) of 1974.

Collective Bargaining Agreements and Participating Employers

A complete list of all of the employers, employer organizations, and employee organizations who are plan sponsors or who participate in this Plan may be obtained by a participant or beneficiary by making a written request for a copy from the Plan Administrator, and is available for examination by participants or beneficiaries at the Funds Office. Participants and beneficiaries also may receive, upon written request, information as to whether a particular employer or employee organization is a Plan Sponsor or participates in the Plan.

A copy of the collective bargaining agreement may be obtained by a participant or beneficiary by making a written request for a copy from the Plan Administrator, and is available for examination by participants or beneficiaries at the Funds Office.

Plan Financing

All contributions to the Health and Welfare Plan are made by employers in accordance with their collective bargaining agreements with the International Union of Operating Engineers, Local 4 or Participation Agreements.

Funding of health and welfare benefits for participants returning from military service earned in accordance with USERRA may be provided, at the Trustees’ election and at their discretion, from the Fund, voluntary employer contributions, collectively bargained employer contributions or the last employer who employed the participant prior to entry into military service. Contributing employers are permitted to make voluntary contributions on behalf of any participant who is serving or who has served in qualified military service, in order to restore their eligibility, regardless of whether they worked for that employer.

The Funds Office will provide you, upon your written request, information as to whether a particular employer is contributing to the Plan on behalf of employees working under the collective bargaining agreements and, if so, that employer’s address. In addition to your request, the Board of Trustees sends an annual Report of Contributions to each participant. You must notify the Funds Office immediately of any company or companies that have failed to pay for you, or that have paid incorrectly.
Your ERISA Rights

The Employee Retirement Income Security Act (ERISA) of 1974, as amended, spells out certain rights and responsibilities relating to the benefit plans described in this Plan Document. The International Union of Operating Engineers, Local 4 Health and Welfare Plan is designed to meet the legal requirements for plans established under ERISA. The Plan will be amended to comply with any applicable changes in the law or government regulations.

As a participant in the Health and Welfare Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to the rights outlined in this section.

Receive Information About Your Plan and Benefits

You have the right to examine, without charge, at the Plan Administrator’s office, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

You have the right to receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, your spouse and your 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. See Continuation of Coverage (COBRA) for the rules governing your COBRA continuation coverage rights.

You have the right to reduce or eliminate exclusionary periods of coverage for pre-existing conditions, should they exist under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group Health Plan or health insurance issuer:

• When you lose coverage under the Plan;
• When you become entitled to elect COBRA continuation coverage;
• When your COBRA continuation coverage ceases;
• If you request it before losing coverage; or
• If you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after the date you enroll in your new coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Document or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a Qualified Medical Child Support Order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

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

**Assistance With Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or: Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.