Your Benefits and Group Legal Services Trust Funds at Work for You
Summary Plan Description
The International Union of Operating Engineers Local 30 Benefits Trust Fund and Group Legal Services Trust Fund are administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees with equal voting power.

<table>
<thead>
<tr>
<th>Union Trustees</th>
<th>Employer Trustees</th>
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<tr>
<td>William M. Lynn, Chairman</td>
<td>Frederick Ward</td>
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<td>Anthony Calandrino</td>
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<td>Kevin Cruse</td>
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<tr>
<th>Fund Coordinator</th>
<th>Fund Auditor</th>
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<tr>
<td>Angelo DePietto</td>
<td>Novak Francella LLC</td>
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<tr>
<th>Fund Counsel</th>
<th>Fund Consultant and Actuary</th>
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<tr>
<td>Barnes, Iaccarino &amp; Shepherd LLP</td>
<td>The Segal Company</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

## INTRODUCTION
- Benefits Trust Fund 1
- Group Legal Services Trust Fund 1

## ELIGIBILITY AND PARTICIPATION
- Who’s Eligible 2
- When Participation Begins 2
- Enrolling for Coverage 3
- When Coverage Ends 3
- Reinstatement of Coverage 4
- Keeping the Fund Informed 4

## LIFE EVENTS AT-A-GLANCE
- If You Get Married 5
- If You Add a Child 5
- If You Get Legally Separated or Divorced 5
- If You Enter the Uniformed Services 6
- If Your Child Loses Eligibility 7
- In the Event of Your Death 7
- If You Take a Family and Medical Leave 7
- If Your Employment Ends: COBRA Continuation Coverage 8
- If Your Employment Ends: Converting Your Coverage To Individual Coverage 11

## WHEN YOU RETIRE
12

## YOUR HEALTH BENEFITS
13

## HOW THE PPO MEDICAL PLAN WORKS
14
- How Benefits Are Determined 14

## EMPIRE BLUECROSS BLUESHIELD
- HOSPITAL CARE 15
- When You Go In-Network 15
- When You Go Out-Of-Network 15
- Empire BlueCard® 15
- Pre-certifying Care 16
- Overview of Eligible Empire BlueCross BlueShield Expenses 17
- Emergency Care 19
- Inpatient Hospital Care 20
- Ambulatory Services 20
- Pregnancy and Maternity Care 21

## MAGNACARE PPO MEDICAL CARE
24
- When You Go In-Network 24
- Selection of a Primary Care Provider 24
- Direct Access to Obstetricians and Gynecologists 24
- When You Go Out-Of-Network 25
- Benefit Maximums 25
- Overview of Eligible MagnaCare Expenses 26
- General Medical Care 29
- Preventive Care 30
- Durable Medical Equipment and Supplies 31
- What’s Not Covered by the PPO Medical Plan (BCBS Hospital and MagnaCare) 31

## CIGNA OPEN ACCESS PLUS IN-NETWORK COPAY PLAN
34
- When You Go In-Network 34
- Prior Authorization 34
- Summary of Benefits 34
- Benefits 35
- Exclusions 38
- Additional Information 39
- Exclusions 40
- Selection of a Primary Care Provider 42
- Direct Access to Obstetricians and Gynecologists 42

## YOUR PRESCRIPTION DRUG BENEFITS
43
- At the Pharmacy 43
- Through Mail Order 43
- Specialty Drug Management Program 44
- If You Use an Out-of-Network Pharmacy 44
- Annual Maximum Benefit 44
- Eligible Drugs 44
- Ineligible Drugs 45

## YOUR DENTAL BENEFITS
46
# TABLE OF CONTENTS continued

## HOW THE HEALTHPLEX DENTAL PPO PLAN WORKS 47
- How Eligible Dental Expenses Are Defined 47
- How to Use the Plan 47
- Maximum Benefits 47
- Pre-treatment Estimate 47
- Schedule of In-Network (PPO) Copayments and Out-of-Network Dental Allowances 48
- Benefits When Alternate Procedures Are Available 50
- Benefits After Coverage Ends 50
- What is Not Covered by the Healthplex Dental Plan 51
- Coordination of Benefits (COB) 51
- How to Claim Dental Benefits 51

## YOUR LIFE INSURANCE BENEFITS 63
- About Your Beneficiary 63
- If You Become Disabled – Waiver of Premium 63
- When Coverage Ends 63
- Conversion Privileges 64
- Claiming Life Insurance Benefits 64

## YOUR ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE BENEFITS 65
- How AD&D Benefits Work 65
- What’s Not Covered 66
- When Coverage Ends 66
- Claiming AD&D Insurance Benefits 66

## GROUP LEGAL SERVICES FUND 67
- Eligibility 67
- How the Plan Works 67
- Amount of Legal Service You Receive 67
- What’s Covered 68
- What’s Not Covered 68

## HOW THE AETNA DMO PLAN WORKS 52
- Your Primary Care Dentist 52
- Overview of Eligible Aetna DMO Expenses 52
- Benefits When Alternate Procedures Are Available 54
- Out-of-Area Emergency Dental Care 54
- Benefits After Coverage Ends 54
- What’s Not Covered by the Aetna DMO Dental Plan 54

## HOW THE DDS, INC. DENTAL PPO PLAN WORKS 56
- Maximum Benefits 56
- Schedule of Benefits (partial listing) 56

## HOW TO CLAIM BENEFITS 69
- Definition of a Claim 69
- How to File Claims 70
- When To File Claims 72
- Authorized Representatives 72
- Making Claims Determinations 72
- Claims Denial Notification 73
- Appealing a Denied Claim (Non-Hospital Claims) 74
- Review Process 74
- Timing of Notice of Decision on Appeal 75
- Notice of Decision on Review 75
- Empire BlueCross BlueShield Complaints, Appeals and Grievances Procedures 76
- External Review for Claim Denied on Appeal (Empire BlueCross BlueShield Hospital Claims) 79
- External Review for Claim Denied on Appeal (Non-Hospital Claims) 79
- Incompetence 82
- Cooperation 83
- Mailing Address 83
- Recovery of Overpayment 83
- No Fault Coverage 83

## YOUR OPTICAL BENEFITS 60
- Eligible Vision Care Expenses 60
- In-Network Benefits 60
- Out-of-Network Benefits 61
- Ineligible Vision Care Expenses 61
- Hearing Aid Benefit 61

## YOUR SHORT-TERM DISABILITY BENEFITS 62
- When Benefits Begin 62
- Duration of Benefit Payments 62
- Disabilities Not Covered by the Plan 62
- Claiming Short-Term Disability Benefits 62
# Table of Contents

## Other Information You Should Know
- Coordination of Benefits  84
- Subrogation  85
- Repayment of Medical Benefits  86
- Confidentiality of Health Care Information  88
- Women’s Health and Cancer Rights Act of 1998 Notice  88
- How Benefits May Be Reduced, Delayed or Lost  88
- Compliance With Federal Law  88
- Amendment and Termination of the Plan  89
- Your Disclosures to the Plan  89
- Plan Administration  89
- Discretionary Authority of the Board of Trustees  89
- Employer Contributions  89
- Rescission of Plan Coverage  89

## Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)
- Information About Your Plan and Benefits  90
- Prudent Actions by Plan Fiduciaries  90
- Enforce Your Rights  90
- Assistance with Your Questions  91

## Plan Facts

## Key Terms and Definitions
This booklet is the Summary Plan Description ("SPD") for the International Union of Operating Engineers Local 30 Benefits Trust Fund and Group Legal Services Trust Fund as of February 1, 2014. It is meant to help you understand how the Plan works. It doesn’t change the official rules and regulations in the official Plan documents, including insurance certificates of coverage, insurance policies, trust agreements and the collective bargaining agreements establishing the Plan. The certificates of coverage and insurance policies for the insured parts of the Plan take precedence over what is included in this document. Rights to benefits are determined only by referring to the full text of official Plan documents (available for your inspection at the Fund Office) or by official action of the Board of Trustees. If there is any conflict between the terms of the official rules and regulations of the Benefits Trust Fund and Group Legal Services Trust Fund or the Plan they have adopted and this Summary Plan Description, the official rules and regulations shall control. In addition, the Board of Trustees reserves the right, in its sole and absolute discretion, to amend or end this Plan at any time.
The International Union of Operating Engineers Local 30 Benefits Trust Fund and Group Legal Services Trust Fund has established a Plan that is designed to help you and your family afford proper health care. The Plan also provides members with disability, life and accident insurance coverage and prepaid legal services. Here are some of the highlights of how the Plan works.

Benefits Trust Fund

- **You choose your medical coverage.** Each year, you can choose to enroll in the Preferred Provider Organization (PPO) Medical Plan or an Exclusive Provider Organization (EPO). Both the PPO and the EPO offer 100% coverage of eligible In-Network hospital expenses and, after a $10 (PPO) or $25 (EPO) copayment per visit, 100% coverage of eligible In-Network doctor charges and other medical expenses. The PPO Medical Plan has an Out-of-Network benefit while the EPO only covers In-Network benefits.

- **You choose your dental coverage, too.** Each year, you can choose to enroll in the fee-for-service (including a PPO feature) Dental Plan administered by Healthplex, the Dental Maintenance Organization Plan (Aetna DMO), or the DDS, Inc. Dental Plan (PPO or fee-for-service). All dental plan options offer extensive coverage of eligible dental expenses.

- **You have two ways to fill prescriptions.** There’s a network of local CVS Caremark retail pharmacies that you can use for short-term prescriptions, and the CVS Caremark mail order pharmacy for long-term prescriptions.

- **Your eye care and eyewear are covered.** Optical benefits are payable for eye exams, eyeglasses, contact lenses and laser vision surgery. Benefits depend on whether you go to your own provider or use a participating vision care center.

- **You have a hearing aid benefit.** You can have a hearing evaluation and obtain a hearing aid for each ear at one of our hearing aid provider locations. See page 61 for more details.

- **When you’re unable to work, you still get a check.** Short-term disability (STD) benefits provide a source of income if you become unable to work due to a non-work-related injury or illness. The STD benefit replaces 50% of your base pay, up to a $170 maximum weekly benefit, for up to 26 weeks of disability.

- **Your family isn’t left high and dry after your death.** You have $50,000 of life insurance coverage through the Union Labor Life Insurance Company (ULLICO). Your life insurance benefit is payable to your spouse or other beneficiary after your death.

- **You’re covered for accidental injuries.** You have $50,000 of accidental death & dismemberment (AD&D) insurance coverage. ULLICO pays $50,000 to your beneficiary if you die in an accident (in addition to the life insurance benefits described above). If you are seriously injured in an accident, the Fund pays either $25,000 or $50,000 (depending on the severity of the injury).

- **You get a head start in paying for retiree medical coverage.** The Fund provides eligible retirees with an annual allowance of $6,000 to purchase retiree health care coverage, up to a $60,000 lifetime maximum benefit through the IUOE Local 30 Private Industry Retiree Benefit Plan.

Group Legal Services Trust Fund

- **You can afford a lawyer when you need one.** You can get up to 10 hours of legal services a year from the Plan, including both phone consultations and legal representation.
Who’s Eligible

Employees. You are eligible to participate in the Plan if you are covered by a collective bargaining agreement between your employer and the Union that requires your employer to make contributions to the Plan on your behalf.

You also are eligible if you are covered by a participation agreement between your employer and the Trustees that requires your employer to make contributions to the Plan on your behalf. Among those who may be Plan participants because of a participation agreement are Union staff, Local 30 Trust Funds staff¹ and employees who hold management positions with a Contributing Employer but who formerly were covered by a collective bargaining agreement that provided for contributions to the Plan.

The “Union” means Local 30 and its subdivisions of the International Union of Operating Engineers, AFL-CIO.

Dependents. You can enroll your eligible Dependents in the same medical and/or dental coverage you choose for yourself. Your eligible Dependents are your spouse and your children, defined as follows.

- **Spouse.** Your spouse is your lawfully married spouse.
- **Children.** Dependent children are your children through the end of the calendar year in which they turn age 26, including:
  - Your biological children.
  - Your lawfully adopted children. If you are adopting a child from birth, the child is considered a Dependent from birth.
  - Your stepchildren.
  - Any other child, including foster children for whom you have proof of legal guardianship, as long as the child lives with you in a parent-child relationship and depends on you for support and maintenance. If you have started legal guardianship procedures, coverage is effective with the filing of the application. For coverage to continue, you must be appointed a legal guardian within three months of filing your application for guardianship.

You may also cover any other Dependent children for whom Plan coverage has been court-ordered through a Qualified Medical Child Support Order (QMCSO) or through a National Medical Child Support Notice (NMCSN). See page 6 for more information on QMCSOs.

Continued coverage for unmarried Dependent children. While coverage normally ends at the end of the calendar year in which a Dependent child reaches his/her 26th birthday, it may be continued beyond then for handicapped children.

Handicapped children. Extended coverage is available for a child who is over age 26, cannot work, and depends on you solely for support because of a mental, developmental or physical disability or illness. You must provide proof to the Fund Office that your child’s disability began before the child reached age 26, and you must do so no later than 31 days after the child’s 26th birthday. For all handicapped children, the Fund Office periodically requires substantiation of the child’s continued handicap, which may include a physical exam. Without this proof, coverage will not be continued.

When Participation Begins

Your participation automatically begins on the first day of the month after you complete eight consecutive weeks of full-time service in covered employment.

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¹ Local 30 Trust Funds staff include employees of this Trust Fund, the IUOE Local 30 Annuity Fund, the IUOE Local 30 Pension Trust Fund, the Industry Stabilization Fund, the Northeastern Engineers Federal Credit Union and the IUOE Local 30 Apprenticeship Training & Skills Improvement Fund.
Enrolling for Coverage

Initial enrollment. You will receive your initial enrollment package from the Fund Office when you first become eligible to participate. This package will include an IUOE Local 30 Benefits Trust Funds Enrollment Form and a Medical Plan Selection Form, among other materials. You must complete and return all applicable enrollment forms within 30 days after you first become eligible; otherwise, you will automatically be enrolled in single coverage for the Plan's default medical and dental coverage, which will be described with your enrollment material. There is no need to elect your other benefits (such as life and accident insurance); coverage automatically begins as soon as you are eligible.

In order for your Dependents to be covered, you will need to enroll them when you are first eligible for coverage. You must enroll your Dependents in the same Medical and Dental Plan as you are enrolled in. If you do not enroll your Dependents within 30 days, you may enroll them late but coverage will not be effective until the first of the month following the month the Fund Office receives the completed enrollment package with the necessary documentation. See the Life Events at a Glance section beginning on page 5 for the documentation you must submit to the Fund Office when adding a Dependent.

Annual enrollment. The Fund Office conducts an annual enrollment each fall, during which you may make changes to your medical and dental elections. The elections you make during annual enrollment go into effect as of the following January 1 and remain in effect for the entire calendar year unless you have a qualified family status change (as described in the Life Events at a Glance section starting on page 5).

Special enrollment. Generally, the Plan does not permit eligible employees or Dependents to decline Plan coverage. However, if the option to decline coverage becomes available or you do not enroll your Dependents when they are first eligible, and if you decline enrollment for (or do not enroll) yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents’ other coverage). However, you must request enrollment within 30 days after your or your Dependents’ other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

You and your Dependents may also enroll in this Plan if you (or your Dependents) have coverage through Medicaid or a State Children’s Health Insurance Program (CHIP) and you (or your Dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

You and your Dependents may also enroll in this Plan if you (or your Dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your Dependents) are determined to be eligible for such assistance.

If you do not enroll your Dependents within the deadlines shown above, you may enroll them late but coverage will not be effective until the first of the month following the month the Fund Office receives the completed enrollment package with the necessary documentation. To request special enrollment or obtain more information, contact the Fund Office.

When Coverage Ends

Your coverage. Your coverage normally ends on the earliest of the following dates:

- The date you fail to meet any of the Fund’s eligibility requirements;
- The end of the month following the month in which you stopped working in covered employment (for example, if your last day at work in full-time covered employment is in December and you have no full-time covered employment in January, your coverage ends on the last day of January);
- The date the Fund is amended to terminate coverage for your employment category.

See “Life Events At A Glance,” page 5, for information about what happens to your coverage if you get married or divorced, have a child, leave covered employment or otherwise change the circumstances of your participation or employment.
Dependent coverage. If your Dependents are enrolled for Plan coverage, their coverage will normally end on the earliest of the following dates:

- The end of the calendar year in which the Dependent no longer meets the definition of a “Dependent” under the Fund;
- The end of the month in which a divorce is finalized;
- The date you are no longer eligible (for any reason).

WE’RE HERE TO HELP

- If you have any questions about eligibility for the Benefits Trust Fund, please call the Fund Office at (718) 847-8484 during normal business hours, or visit our web site (www.iuoelocal30.org) 24 hours a day, seven days a week.

Keeping the Fund Informed

The best way to ensure fast and accurate claims payment is to make sure the Fund Office has the most up-to-date information for you and your eligible Dependents. In particular, please contact the Fund Office whenever you or your spouse:

- Changes name;
- Changes address;
- Adds an eligible Dependent;
- Changes telephone number;
- Changes marital status (marriage, legal separation or divorce); or
- Dies.

Reinstatement of Coverage

If your eligibility ends, you will need to meet the Plan’s initial eligibility requirements to reinstate your eligibility for coverage (see page 2). However, if you return to covered employment within 60 days, your coverage is reinstated retroactively with no break in coverage. These reinstatement rules are subject to the terms of the collective bargaining agreement, which may require a waiting period before eligibility is re-established.
Your benefits are designed to meet your needs at different stages of your life. This section describes how your Plan benefits are affected when different life cycle changes occur after you become a participant.

If You Get Married
When you get married, your spouse becomes eligible for hospital/medical, prescription drug, dental and optical benefits. Coverage for your spouse begins on the date of your marriage, as long as you notify the Fund Office within 30 days after your marriage date. See the Special Enrollment section on page 3 for enrollment information. At this time, you also may want to update your beneficiary information for your life and AD&D insurance benefits.

If your spouse is covered under another group medical plan, you must report the other coverage to the Fund Office by submitting a copy of your other plan’s insurance card. The amount of benefits payable under this Plan will be coordinated with your spouse’s other coverage, as described on page 84.

If You Add a Child
Your biological child will be eligible for coverage on his or her date of birth. If you have guardianship for a child, adopt a child, or have a child placed with you for adoption, coverage will become effective on the date of placement as long as you are responsible for health care coverage and the child meets the Plan’s definition of a Dependent. (If you are adopting a child from birth, the child is considered a Dependent from birth.) Stepchildren are eligible for coverage on the date of your marriage. Once you provide any required information, coverage for your child will begin. The child must meet the Dependent eligibility requirements described on page 2. See the Special Enrollment section on page 3 for enrollment information.

When you add a child, provide the Fund Office with:

- The birth date, effective date of adoption or placement for adoption, or the date of your marriage (for stepchildren)
- A copy of the birth certificate, adoption papers, court order, or marriage certificate (for stepchildren)
- A copy of your child’s other medical insurance information, if he or she is covered under another plan.

When you get married, you must provide the Fund Office with:

- A copy of your marriage certificate
- Your spouse’s date of birth
- A copy of your spouse’s medical insurance information, if he or she is covered under another plan.

If You Get Legally Separated or Divorced
If you and your spouse get a legal separation or divorce, your spouse will no longer be eligible for coverage as a Dependent under the Plan. However, your spouse may elect to continue coverage under COBRA for up to 36 months. You or your spouse must notify the Fund Office within 60 days of the divorce or legal separation date for your spouse to obtain COBRA Continuation Coverage (see page 8). At this time, you may also want to review your beneficiary designation for your life insurance and AD&D insurance benefits, if eligible.
If you legally separate or divorce, provide the Fund Office with:

- A copy of your separation or divorce decree
- If you have children for whom you do not have custody, a copy of any QMCSO.

If your spouse wants to continue coverage, he or she must contact the Fund Office and enroll for COBRA Continuation Coverage.

Qualified Medical Child Support Orders (QMCSOs). If you are eligible for coverage under the Plan, you may be required to provide coverage for your child pursuant to a Qualified Medical Child Support Order (QMCSO). A QMCSO is a judgment, decree or order issued by a state court or agency that creates or recognizes the existence of an eligible child’s right to receive health care coverage. The Order must comply with applicable law and must be approved and accepted as a QMCSO by the Plan Administrator in accordance with Plan procedures. A copy of the Plan’s QMCSO qualification procedures and a sample is available, free of charge, at the Fund Office.

If You Enter the Uniformed Services

If you are called into the Uniformed Services for up to 31 days, your health coverage will continue as long as you make the required self-payment. If you are called into the Uniformed Services for more than 31 days, you may continue your coverage by paying the required self-payments for up to 24 consecutive months or, if sooner, the end of the period during which you are eligible to apply for reemployment in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you do not continue coverage under USERRA. If you do not continue coverage under USERRA, your coverage will end immediately when you enter the Uniformed Services. Your Dependents will have the opportunity to elect COBRA Continuation Coverage.

Reinstating your coverage. When you are discharged or released from the Uniformed Services, you may apply for reemployment with your former employer in accordance with USERRA. Reemployment includes the right to elect reinstatement in the existing health coverage provided by your employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of service in the Uniformed Services. When you are discharged or released from service in the Uniformed Services that was:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for a participating employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a participating employer; or
- More than 180 days, you have up to 90 days after discharge to return to work for participating employer.

When you are discharged, if you are hospitalized or recovering from an illness or injury that was incurred during your service in the Uniformed Services, you have until the end of the period that is necessary for you to recover to return to, or make yourself available for, work for a participating employer. Your prior eligibility status will be frozen when you enter the Uniformed Services until the end of the leave, provided your employer properly grants the leave under the federal law and makes the required notification and payment to the Fund.

Uniformed Services, as used herein, means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Coverage under USERRA will run concurrently with COBRA Continuation Coverage. The cost of continuation coverage under USERRA will be the same cost as COBRA Continuation Coverage. The procedures for electing coverage under USERRA will be the same procedures described in the If Your Employment Ends: COBRA Continuation Coverage section beginning on page 8, except that only the Employee has the right to elect USERRA coverage for himself or herself and his/her Dependents, and that coverage will extend to a maximum of 24 months.

Your coverage will continue to the earliest of the following:

- The date you or your Dependents do not make the required self-payments;
- The date you reinstate your eligibility for coverage under the Plan;
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA;
- The date you lose your rights under USERRA (for instance, for a dishonorable discharge);
- The last day of the month after 24 consecutive months; or
- The date the Fund no longer provides any group health benefits.

You need to notify the Fund Office in writing when you enter the Uniformed Services. For more information about self-payments under USERRA, contact the Fund Office.
If Your Child Loses Eligibility
In general, your child is no longer eligible for coverage at the end of the calendar year in which he or she reaches age 26 or is no longer considered disabled if covered. You must notify the Fund Office within 60 days of the date your child is no longer eligible for coverage. Your child may elect to continue coverage by making COBRA self-payments for up to 36 months (see page 8).

In the Event of Your Death
If you are an active participant and eligible for coverage on the date of your death, your beneficiary will receive a life insurance benefit (and an AD&D insurance benefit, if your death is accidental). See pages 63 and 65 for more information about life and AD&D insurance benefits.

Medical benefits will continue for your surviving Dependents for up to one year following your death if your Dependents are not eligible for other health coverage. Your surviving Dependents may be eligible for COBRA continuation coverage following your death or after Plan continuation ends. See page 8 for more information.

In the event of your death, your spouse or beneficiary should:
- Notify the Fund Office
- Provide the Fund Office with a copy of your death certificate
- Apply for your life insurance (and AD&D insurance, if applicable).

If You Take a Family and Medical Leave
The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:
- The birth or adoption of a child or placement of a child with you for foster care or adoption;
- The care of a seriously ill spouse, parent, or child;
- Your serious illness; or
- You have an urgent need for leave because your spouse, son, daughter, or parent is on active duty in the Uniformed Services.

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 Uniformed Services member. The member of the Uniformed Services 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 the Uniformed Services; and
- Be an outpatient, or on the temporary disability retired list of the armed services for a serious illness or injury.

Note that a family and medical leave of absence is not granted to care for a parent-in-law.

During your leave, you will maintain medical coverage offered through the Fund. You are eligible for a leave under FMLA if you:
- Have worked for a covered employer for at least 12 months;
- Have worked at least 1,250 hours during the previous 12 months; and
- Work at a location where at least 50 employees are employed by the employer within a 75-mile radius of the employer’s location.

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

You may be required to provide:
- 30-day advance notice of the leave, if possible;
- Medical certifications supporting the need for a leave; and/or
- Second or third medical opinions and periodic recertification (at your employer’s expense) and periodic reports during the leave regarding your status and intent to return to work.

Your leave will end on the earlier of your return to work or 12 weeks. If you do not return to work within 12 weeks, you may qualify for COBRA continuation coverage (see page 8).

If you and your spouse both work for the same employer, you and your spouse are eligible for a combined total of 12 weeks of leave during a 12-month period. You should contact your employer if you have any questions on taking a leave.
If Your Employment Ends: COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”), requires that the Fund offer you and your eligible Dependents the opportunity for a temporary extension of health care coverage at group rates in certain instances where your coverage would otherwise end (called “qualifying events”). Continued coverage under COBRA applies to the health care benefits described in this booklet. You don’t have to prove good health to get COBRA coverage. However, you are required to pay the full cost of coverage for both you and any covered Dependents (plus a 2% administrative fee).

Under COBRA, you and your enrolled Dependents have the right to elect to continue coverage under the Plans if you (or your enrolled Dependents) would otherwise lose coverage because of a qualifying event (as shown in the chart below). Each qualified beneficiary has the independent right to elect COBRA coverage. A qualified beneficiary means each person (you, your spouse and your Dependents) covered by the Plan on the day before a qualifying event, and any child born to you (the employee) or placed for adoption with you while you are covered by COBRA. COBRA coverage is identical to the coverage provided to similarly situated active participants. You may elect COBRA continuation on behalf of your spouse, as long as your spouse is a qualified beneficiary. Parents may elect COBRA continuation coverage on behalf of their Dependent children, as long as the Dependent children are qualified beneficiaries.

Please note: The explanation of COBRA in this section is not intended to give you or your enrolled Dependents any rights to COBRA that are not otherwise required by law.

The following chart shows the qualifying events and the periods of eligibility for COBRA continuation coverage:

<table>
<thead>
<tr>
<th>If You Lose Coverage Because of This Qualifying Event...</th>
<th>These People Would Be Eligible for COBRA Coverage...</th>
<th>For Up To...</th>
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<tbody>
<tr>
<td>Your employment terminates for reasons other than gross misconduct</td>
<td>You and your eligible Dependents</td>
<td>18 months²</td>
</tr>
<tr>
<td>You become ineligible due to reduced work hours</td>
<td>You and your eligible Dependents</td>
<td>18 months²</td>
</tr>
<tr>
<td>You die</td>
<td>Your eligible Dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>You divorce or legally separate</td>
<td>Your eligible Dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>Your Dependent children no longer qualify as Dependents</td>
<td>Your eligible Dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>You become entitled to Medicare</td>
<td>Your eligible Dependents</td>
<td>36 months</td>
</tr>
</tbody>
</table>

Please note that entitlement to Medicare means you are eligible for and enrolled in Medicare. Also note that if you are entitled to Medicare at the time that your employment terminates or you become ineligible due to a reduction in hours and your Medicare entitlement began less than 18 months before the applicable qualifying event, your Dependents will be eligible for up to 36 months of COBRA after the date of Medicare entitlement.

Proof of good health is NOT required for COBRA coverage.

Extension of 18-month COBRA coverage period for disability. If you’re a qualified beneficiary who has COBRA continuation coverage because of termination of employment or a reduction in hours, you and each enrolled member of your family can get an extra 11 months of COBRA coverage if you become disabled (that is, you can get up to a total of 29 months of COBRA coverage). To qualify for additional months of COBRA coverage, you must have a Notice of Award from the Social Security Administration that your disability began before the 61st day after your termination of employment or reduction in hours, and your disability must last at least until the end of the COBRA coverage period that would have been available without the extension.

To elect extended COBRA coverage, you must send a copy of the Social Security Administration’s determination to the Fund Office within 60 days of the date of the Social Security Administration’s determination notice (or the date of the qualifying event or the date coverage was or would be terminated as a result of the qualifying event, whichever is latest). In addition, your notification to the Fund Office must occur within 18 months after your termination of employment or reduction in hours. If you do not notify the Fund Office in writing within the 60-day (and 18-month) period, you will lose your right to elect extended COBRA continuation coverage.

Extension of 18-month COBRA coverage period for your spouse or Dependent children due to a second qualifying event. If your spouse or Dependent children have COBRA continuation coverage because of your termination of employment or reduction in hours, they can get up to

² Continued coverage for up to 29 months from the date of the initial event may be available to those who, during the first 60 days of continuation coverage, become totally disabled within the meaning of Title II or Title XVI of the Social Security Act. These additional 11 months are available to participants and enrolled Dependents if written notice of disability is provided to the Fund Office before the 18-month continuation period runs out and within 60 days of the date of the Social Security Administration’s determination notice (or the date of the qualifying event or the date coverage was or would be terminated as a result of the qualifying event, whichever is latest).
an extra 18 months of COBRA coverage if they have a second qualifying event (that is, they can get up to a total of 36 months of COBRA coverage). This extended COBRA coverage is available to your spouse and Dependent children if the second qualifying event is your death, divorce or legal separation. The extension is also available to a Dependent child whose second qualifying event occurs when he or she stops being eligible under the Plan as a Dependent child.

To elect extended COBRA coverage in all of these cases, you must notify the Fund Office of the second qualifying event within 60 days after the second qualifying event (or the date that benefits would end under the Plans as a result of the first qualifying event, if later). If you do not notify the Fund Office in writing within the 60-day period, you will lose your right to the extended COBRA continuation coverage.

**Notification.** In general, your employer is responsible for notifying the Fund Office if you or your Dependent become eligible for COBRA continuation coverage because of your death, termination of employment, reduction in hours of employment or Medicare entitlement. The notification must be made within 30 days after the qualifying event.

Under the law, you or your enrolled Dependent is responsible for notifying the Fund Office in writing of your divorce, your legal separation or a child’s loss of Dependent status. The notification must be made within 60 days after the qualifying event (or the date on which coverage would end because of the qualifying event, if later).

A disabled qualified beneficiary must notify the Fund Office in writing of a disability determination by Social Security within 60 days after such determination (or the date of the qualifying event or the date coverage was or would be terminated as a result of the qualifying event, whichever is latest) and within the initial 18 months of COBRA coverage.

You or your family member can provide notice on behalf of yourself as well as other family members affected by the qualifying (or second qualifying) event. The written notice of the qualifying event should be sent to the Fund Office, at the address shown on the inside cover, and should include the following, along with a copy of the applicable proof of the qualifying event:

- **Date written notice is submitted** (month/day/year)
- **Participant’s name**
- **Participant’s Social Security Number/ID number**
- **Reason for loss of coverage**
- **Loss of coverage date** (month/day/year)
- **Spouse/Dependent’s name**
- **Spouse’s Social Security Number/ID number**
- **Spouse/Dependent’s address**
- **Spouse/Dependent’s telephone number**
- **Spouse/Dependent’s gender**
- **Spouse/Dependent’s date of birth**
- **Spouse/Dependent’s relationship to employee**
- **Spouse/Dependent’s employer’s name.**

If you do not notify the Fund Office in writing within the applicable 60-day period or you do not follow the procedures prescribed for notifying the Fund Office, you will lose your right to elect COBRA continuation coverage.

**COBRA enrollment.** Within 14 days after the Fund Office is notified that a qualifying event has occurred, they will send you an election form and a notice of your right to elect COBRA. (If you do not receive this notification, please contact the Fund Office.) To receive COBRA continuation coverage, you must elect it by returning a completed COBRA election form to the Fund Office within 60 days after the date of the notice of your right to elect COBRA (or within 60 days after the date you would lose coverage, if later).

If you make this election and pay the required premium within the required deadlines, COBRA coverage will become effective on the day after coverage under the Plan would otherwise end. If you do not elect COBRA, your coverage under the Plan will end in accordance with the provisions listed under When Coverage Ends, page 3.

In considering whether to elect COBRA coverage, please note that if you decline COBRA coverage, it will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Keep in mind that under federal law, you have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.
Adding a Dependent after COBRA coverage begins. If a child is born to you (the participant) or placed for adoption with you while you are covered by COBRA, you can add the child to your coverage as a qualified beneficiary with independent COBRA rights. In addition, each qualified beneficiary covered by COBRA may add Dependents in the same manner as an active employee, but such Dependents are not qualified beneficiaries.

Cost of coverage. As provided by law, you and/or your enrolled Dependents must pay the full cost of coverage plus 2% for administrative expenses for the full 18- or 36-month period. For a disabled person who extends coverage for more than 18 months, the cost for months 19-29 is 150% of the Fund’s cost for the coverage. When two or more family members elect COBRA coverage, the family coverage cost under the Plan will apply. Since the cost to the Fund may change during the period of your continuation coverage, the amount charged to you may also change annually during this period.

Time for payment. You must send the initial payment for COBRA coverage to the Fund Office within 45 days of the date you first notify the Fund Office that you choose COBRA coverage (a U.S. Post Office postmark will serve as proof of the date you sent your payment). You must submit payment to cover the number of months from the date of regular coverage termination to the time of payment (or to the time you wish to have COBRA coverage end).

After your initial payment, all payments are due on the first of the month. You have a 30-day grace period from the due date to pay your premium. If you fail to pay by the end of the grace period, your coverage will end as of the last day of the last fully paid period. Once coverage ends, it cannot be reinstated. To avoid cancellation, you must send your payment on or before the last day of the grace period (again, a U.S. Post Office postmark will serve as proof). Please note that if your check is returned unpaid from the bank for any reason, that may prevent your COBRA premiums from being paid on time and may result in cancellation of coverage.

When COBRA continuation coverage ends. COBRA continuation coverage ends automatically on the last day of the month in which the earliest of the following dates falls:

- The date the maximum coverage period ends
- The last day of the period for which the person covered under COBRA made a required premium payment on time
- The date after the election of COBRA that the person covered under COBRA first becomes covered under another group medical plan. If the other plan limits coverage because of the person’s pre-existing condition, COBRA coverage will end after the pre-existing condition no longer applies
- The date after the election of COBRA that the person covered under COBRA first becomes entitled to Medicare
- The first of the month that begins more than 30 days after the date the person whose disability caused the extension of coverage to 29 months is no longer disabled (based on a final determination from the Social Security Administration)
- The date the Plan is terminated and the Fund provides no other medical coverage.

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

COBRA continuation coverage cannot under any circumstances extend beyond 36 months from the date of the qualifying event that originally made you or a Dependent eligible to elect COBRA.

Once COBRA continuation coverage ends for any reason, it cannot be reinstated.

You must notify the Fund Office if:

- You have a divorce or legal separation
- You, your spouse or an eligible enrolled Dependent has a change of address
- You or your spouse or your Dependent becomes entitled to for Medicare
- Your Dependent child is no longer eligible
- You or a Dependent ceases to be disabled, as determined by the Social Security Administration.

If you don’t notify the Fund Office in a timely manner that any of the above events has occurred, you may lose COBRA coverage.

All notices to the Fund Office must be in writing and sent to the Fund Office at the address on the inside cover. Any notice that you send must be postmarked by the U.S. Post Office no later than the last day of the required notice period. The notice must state the name of the Plan under which you request COBRA continuation coverage, your name and address, the name and address of each qualifying beneficiary, the qualifying event and the date it happened. If the qualifying event is a divorce or legal separation, you must include a copy of the divorce decree or legal documentation of the legal separation. Other applicable documentation (such as birth certificates or adoption papers) may also be required.
Unavailability of coverage. If you or your enrolled Dependent has notified the Fund Office in writing of your divorce, your legal separation or a child’s loss of Dependent status, or a second qualifying event, but you or your enrolled Dependent is not entitled to COBRA, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA. This notice will be provided within the same time frame the Plan follows for election notices.

Additional COBRA election period under the Trade Act. If the U.S. Department of Labor (DOL) certifies you as eligible for benefits under the Trade Act of 2002, you may be eligible for both an additional 60-day COBRA election period and an individual health insurance tax credit. For more information about COBRA and the Trade Act, go to www.irs.gov and enter “HCTC” in the “Search for…” box on the home page, or call the Health Care Tax Credit Customer Contact Center toll-free at (866) 628-4282. (TTD/TTY callers may call toll-free at (866) 626-4282.) The Fund Office may also be able to assist you with your questions.

If you have questions. If you have any questions about your COBRA continuation coverage, contact the Fund Office or the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory. Addresses and phone numbers of EBSA offices are available at www.dol.gov/ebsa.

To protect your family’s rights to COBRA coverage, keep the Fund Office informed of any changes of address for you and your family members.

Your Rights Under the Health Insurance, Portability and Accountability Act of 1996 (“HIPAA”). If your Benefits Trust Fund coverage ends, you and/or your Dependents are entitled by law to, and will be provided with, a “Certificate of Creditable Coverage.” Certificates of Creditable Coverage indicate the period of time you and/or your Dependents were covered under the Fund (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your Dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy within 63 days after your coverage under this Fund ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to you and/or your Dependents under the new group health plan or health insurance policy.

The Plan or health insurance issuer will automatically provide you with a Certificate of Creditable Coverage when you are entitled to elect COBRA; when your coverage terminates, even if you are not entitled to COBRA; or when your COBRA coverage ends. You may also request a Certificate of Creditable Coverage free of charge within 24 months after your Plan coverage ends or at any time you are covered under the Plan. You should hold onto these Certificates of Creditable Coverage as proof of prior coverage for your new health Plan. For more information, call the Fund Office.

If Your Employment Ends: Converting Your Coverage To Individual Coverage

Life insurance. If you wish to convert your group life insurance to an individual life insurance policy after your life insurance benefit ends, you must apply to the insurance company in writing and pay the first premium within 31 days after your employment ends. See page 63 in the Life Insurance section for more details.

Contact the Fund Office for more information about converting coverage.

All other Fund benefits. You cannot convert prescription drug, dental, vision, short-term disability, legal, or accidental death & dismemberment benefits to individual coverage.
Coverage for you and your Dependents will end under the active Plan when you retire. You and your Dependents may be eligible for COBRA continuation coverage as described beginning on page 8. However, if you meet certain eligibility requirements, you may be eligible to participate in the IUOE Local 30 Private Industry Retiree Benefit Plan, which provides an annual Retiree Allowance that can help you pay for retiree medical coverage.

Eligibility. You’re eligible for the annual Retiree Allowance if you meet all of the following requirements:

- You’re receiving health benefits as an active participant of the Fund when you retire
- You received health benefits as an active participant of the Fund for at least three out of the last five years of service prior to retirement
- You are in either of the following categories:
  - you retire on or after December 31, 2000 when you’re at least age 62 and have at least 25 years of Fund participation
  - you retire on a disability pension at any age and have at least 20 years of Fund participation when you retire (you also must have at least one day of service since December 31, 2000).

The Retiree Allowance is available only if you have permanently stopped working in the industry and trade. If you return to work in covered employment and regain eligibility under the Plan as an Active Participant, your Retiree Allowance is suspended until you stop working again. If you return to work in the industry or trade outside of covered employment, you will no longer be eligible for the Retiree Allowance.

Contact the Fund Office to find out the current rates for self-pay coverage.

You must notify the Fund Office when you retire. The Fund Office will then determine if you are eligible for the Retiree Allowance and will provide you with the appropriate paperwork.

If you qualify for a Retiree Allowance, it will reimburse you for the cost of retiree health coverage you purchase on your own, subject to a $6,000 annual maximum reimbursement ($1,500 per quarter/$500 per month) and to a $60,000 lifetime maximum reimbursement. If you die before you receive $60,000 in reimbursements, your surviving spouse receives 50% of your monthly benefit up to the remainder of the lifetime cap.

If you are eligible for Medicare and you began using your Retiree Allowance to be reimbursed for the cost of self-pay coverage prior to January 1, 2014, the Fund will continue to reimburse you for the cost of self-pay coverage until you reach the lifetime maximum or you are otherwise no longer eligible for coverage.

All other eligible retired participants, whether eligible for Medicare or not, can use the Retiree Allowance only to help pay the cost of health coverage you purchase on your own.

You will receive more detailed information about the IUOE Local 30 Private Industry Retiree Benefit Plan when you retire—or if you request it from the Fund Office.

When you retire:

- Notify the Fund Office in advance of your retirement.
- Apply for the Retiree Allowance, if you are eligible.
Every year, during annual enrollment, you have the option to select either the:

• Preferred Provider Organization (PPO) Medical Plan; or

• Exclusive Provider Organization (EPO) Medical Plan

to provide coverage for you and your eligible Dependents. Although both plans provide comprehensive medical care coverage, the way that each plan delivers care and pays benefits is very different.

For example, with the PPO you may visit any provider you would like without needing a referral. The EPO in many ways operates like an HMO but without the requirement of a primary care doctor designation. The EPO does not cover any services you receive Out-of-Network.

The following sections describe how both medical options operate. If you have any questions, be sure to call the Fund Office or the insurance provider.

During annual enrollment, make sure you understand how your medical plan options work so that you select the plan that will best suit your and your family’s needs. Your Dependents must be enrolled in the same medical option as you.
There are two components to the Preferred Provider Organization (PPO) Medical Plan:

- **Hospital benefits, administered by Empire BlueCross BlueShield.** The Plan covers inpatient services at 100% for medically necessary charges at participating In-Network hospitals. If you go to a non-participating or Out-of-Network hospital, the Plan will pay 80% of the allowed amount. Your Empire Blue Cross benefits also cover some outpatient services. A description of Hospital Care Benefits begins on page 17.

- **Medical benefits, administered by MagnaCare.** Under the Plan, you are free to choose any provider you wish to provide you with health care. However, the Plan has contracted with MagnaCare to provide In-Network benefits at a lower cost to you and your family. In-Network providers have agreements with MagnaCare in which they provide health care services and supplies for a favorable negotiated fee applicable only to Plan participants. When you and/or your Dependents use the service of an In-Network provider, you generally are responsible for paying only the applicable copayment for any medically necessary covered services. For Out-of-Network providers, the Plan pays 80% of the allowed amount for eligible expenses after you pay a deductible. See page 24 for more details.

Although the Plan recommends that you have a primary care physician (PCP) to help manage your health care, the PPO does not require you to have one. You may self-refer to any physician at any time. However, when you use PPO In-Network providers, you receive the highest level of benefits and have the lowest out-of-pocket costs.

Any proposed hospital stays and certain outpatient procedures must be certified by MedReview prior to admission. When you are hospitalized for an emergency, you must notify MedReview of your emergency admission within 48 hours after you have been admitted. Failure to follow these rules may result in substantial out-of-pocket costs that may be your responsibility to pay. MedReview can be contacted at (800) 688-2284. See page 16 for more details.

**How Benefits Are Determined**

The Plan uses these rules in paying benefits.

- **Charges must be for necessary care.** The Plan will pay benefits only for services, supplies and equipment that Empire or MagnaCare (whichever applies) considers to be medically necessary.

- **Charges for Out-of-Network services.** The Plan will pay benefits for covered Out-of-Network services up to the allowed amount. You’ll be responsible for paying coinsurance, plus any amount above the allowed amount. The allowed amount is based on an agreement between Empire and the provider, or if there is no agreement, then on the customary charge or the average market charge in your geographic area for a similar service. You are responsible for paying the entire portion above the allowed amount.

- **Charges for In-Network services.** If you go to a Network provider, the provider should accept what Empire/MagnaCare pays (subject to applicable copays) and shouldn’t charge you more than the allowed amount.

- **Charges must be incurred while covered.** The Plan will not reimburse any expenses incurred by a person while the person is not covered under the Plan.
Empire BlueCross BlueShield administers your hospital benefits. Its operating area, or in-area benefits, covers the 28 counties of Eastern New York, which includes New York City, as well as various hospital affiliations nationwide (see below).

Your Empire BlueCross BlueShield benefits cover specific medical expenses that result from a non-occupational illness or injury. Most medically necessary expenses you or your family incurs at hospitals and other medical facilities are considered covered expenses, subject to certain Plan limitations. But certain services are not covered at all, and some are only partially covered, or covered only up to certain limits, as described starting on page 31.

When You Go In-Network

The Plan generally pays 100% of the allowed amount when you use an Empire BlueCross BlueShield In-Network hospital. An Empire BlueCross BlueShield participating hospital is one with which Empire BlueCross BlueShield has a written agreement for the provision of care to its subscribers and which it specifically recognizes as an acute care general or specialty hospital. A participating hospital may have a separate section or facility that specializes in the treatment of one condition that is not covered by an agreement with that hospital.

When You Go Out-Of-Network

If you go to a hospital that is Out-of-Network, the Plan will pay 80% of the allowed amount. You will be responsible for the other 20% (this amount is called your coinsurance), plus all charges above the allowed amount. Your 20% coinsurance is limited each year to $1,000 if you elect individual coverage or $2,500 if you elect family coverage (no matter how many Dependents you enroll).

When you obtain health care through the BlueCard Program, the portion of your claim that you are responsible for (“member liability”) is, in most instances, based on the lower of the following:

- The billed amount that the participating provider actually charges for covered services, or
- The negotiated price that the local Blue Plan passes on to Empire.

Here’s an example of a negotiated price and how it benefits you:

A provider’s standard charge is $100, but he/she has a negotiated price of $80 with the local Blue Plan. If your coinsurance is 20%, you pay $16 (20% of $80) instead of $20 (20% of $100).

The negotiated price may reflect:

- A simple discount from the provider’s usual charges, which is the amount that would be reimbursed by the local Blue Plan;
- An estimated price that has been adjusted to reflect expected settlements, withholdings, any other contingent payment arrangements and any non-claim transactions with the provider; or

Empire BlueCard®

The BlueCard Program helps reduce your costs when you obtain Out-of-Network care from a provider who participates with another BlueCross and/or BlueShield plan (“local Blue Plan”) outside the geographic area served by Empire. Just show your Empire ID card to a participating provider and comply with the other terms in the certificate of coverage when receiving these services.
The provider’s billed charges adjusted to reflect average expected savings that the local Blue Plan passes on to Empire. If the negotiated price reflects average savings, it may vary (more or less) from the actual price than it would if it reflected the estimated price.

A small number of states have laws that require that your member liability be calculated based on a method that does not reflect all savings realized, or expected to be realized, by the local Blue Plan on your claim, or that requires that a surcharge be added to your member liability. If you receive covered health care services in any of these states, member liability will be calculated using the state’s statutory methods that are in effect at the time you receive care.

If you have questions about the BlueCard Program, contact Member Services.

BlueCard PPO Program. Nationwide, BlueCross and BlueShield plans have established PPO Networks of hospitals and other health care providers. By presenting your Empire BlueCross BlueShield ID card to a hospital participating in the BlueCard PPO Program, you receive the same In-Network benefits as you would receive from an Empire PPO Network hospital. The suitcase logo on your ID card indicates that you are a member of the BlueCard PPO Program. Call (800) 810-BLUE (2583) or visit www.bcbs.com to locate participating providers.

Pre-certifying Care

You must get certain kinds of care pre-certified in order to qualify for the maximum benefit payable. This means that in order for you to get the highest level of benefits for some services, you have to contact the Plan’s Medical Management Program before the procedure is performed. (For ongoing care like hospitalization or continuing home health care, you or your doctor may be required to call periodically to renew certification.)

To pre-certify care, call MedReview at (800) 688-2284. You can reach them 24 hours a day, seven days a week.

Pre-certification is your responsibility, so you must call to do it. You or your provider must contact MedReview to pre-certify the following medical services and supplies within the following time frames. (If you can’t make the call yourself, you can have someone else do it for you. The important thing is that the call is made before the care is provided.)

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>When You Must Call</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient (In a Hospital Setting)</strong></td>
<td></td>
</tr>
<tr>
<td>■ Air ambulance</td>
<td>As soon as possible before you receive care</td>
</tr>
<tr>
<td>■ Cardiac rehabilitation</td>
<td></td>
</tr>
<tr>
<td>■ Home health care and home infusion</td>
<td></td>
</tr>
<tr>
<td>■ Hospice care</td>
<td></td>
</tr>
<tr>
<td>■ Speech, occupational, hearing and vision therapy</td>
<td></td>
</tr>
<tr>
<td>■ MRI or MRA exams</td>
<td></td>
</tr>
<tr>
<td>■ Physical therapy (after 20 visits)</td>
<td></td>
</tr>
<tr>
<td>■ Pregnancy</td>
<td></td>
</tr>
<tr>
<td><strong>Surgical procedures</strong></td>
<td></td>
</tr>
<tr>
<td>(inpatient and ambulatory)</td>
<td>Two weeks before you receive care or as soon as care is scheduled, whichever is earlier</td>
</tr>
<tr>
<td><strong>Inpatient: all inpatient admissions</strong></td>
<td></td>
</tr>
<tr>
<td>■ Scheduled hospital admissions</td>
<td>Two weeks before you receive care or as soon as care is scheduled, whichever is earlier</td>
</tr>
<tr>
<td>■ Admissions to skilled nursing or</td>
<td></td>
</tr>
<tr>
<td>rehabilitation facilities</td>
<td></td>
</tr>
<tr>
<td>■ Maternity admissions</td>
<td>Within 48 hours of delivery or admission</td>
</tr>
<tr>
<td>■ Emergency admissions</td>
<td></td>
</tr>
<tr>
<td>■ Maternity admissions lasting longer than two days (four days for cesarean delivery)</td>
<td>As soon as you know care is lasting longer than originally planned</td>
</tr>
<tr>
<td>■ Ongoing hospitalization</td>
<td></td>
</tr>
</tbody>
</table>

How pre-certification works. MedReview will review the proposed care to certify the length of stay or number of visits (as applicable) and will approve or deny coverage for the procedure based on medical necessity. They will then send you a written statement of approval or denial within three business days after they have received all necessary information. In urgent care situations, MedReview will make its decision within 72 hours after they have received all necessary information.

If you don’t pre-certify. If you don’t pre-certify the care listed above within the required time frames, benefit payments will be reduced by 50% to a maximum of $2,500. If the admission or procedure is not medically necessary, no benefits are payable.
Case management. MedReview’s Case Management staff can help you and your family explore your options and make the right treatment choices when you’re facing a chronic or complicated illness or injury. Case Management is designed for complex treatments that can last a long time, such as cancer, heart disease, diabetes, or spinal cord and other traumatic injuries.

Helpful hints when you call to pre-certify. To make pre-certification go as smoothly as possible, have the following information about the patient ready when you call:

- Name, birth date and gender
- Address and telephone number
- Empire BlueCard® ID number
- Name and address of the hospital/facility

Name and telephone number of the admitting doctor

Reason for admission and nature of the services to be performed.

If you lose your ID card, call the Fund Office to request a new one.

Overview of Eligible Empire BlueCross BlueShield Expenses

<table>
<thead>
<tr>
<th>Provision</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>How You Access Care</td>
<td>Go to any Network provider.</td>
<td>Go to any licensed/certified provider who participates with another BlueCross and/ or BlueShield plan through the Blue Card Program.</td>
</tr>
<tr>
<td>Basis for Reimbursement</td>
<td>All In-Network reimbursements are based on the allowed amount for medically necessary eligible expenses and subject to pre-certification where required. Network providers have agreed to accept the allowed amount as payment in full.</td>
<td>All Out-of-Network reimbursements are based on the allowed amount for medically necessary eligible expenses and subject to coinsurance and to pre-certification where required. Out-of-Network providers may or may not accept Empire’s payment as payment in full (excluding deductibles and coinsurance); if they don’t, you are responsible for paying every dollar of the excess.</td>
</tr>
<tr>
<td>Coinsurance (where applicable)</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount</td>
</tr>
<tr>
<td>Annual Coinsurance Maximum</td>
<td>Not applicable</td>
<td>$1,000</td>
</tr>
<tr>
<td>- individual</td>
<td></td>
<td>$2,500</td>
</tr>
<tr>
<td>- family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Care</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Inpatient Hospital Admissions for Medical/ Surgical Treatment³</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Physical Therapy³</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Benefits limited to 60 days/year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

³ Pre-certification required
<table>
<thead>
<tr>
<th>Provision</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Admissions for Alcohol and Substance Abuse Treatment</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Non-Hospital Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Alcohol and Substance Abuse Treatment</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Home Health Care&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td></td>
<td>Benefits limited to 200 visits/year</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility Care&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Plan pays 100% for up to 60 days/year</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hospice Care&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td></td>
<td>Benefits limited to 210 days/lifetime</td>
<td></td>
</tr>
<tr>
<td>Outpatient Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgery&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Pre-surgical Testing</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Mammography</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Physical Therapy&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td></td>
<td>Benefits limited to 30 visits/year</td>
<td></td>
</tr>
<tr>
<td>Diagnostic X-ray and Lab Tests</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>MRI/MRA Tests&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Occupational/Speech/Vision Therapy&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td></td>
<td>Benefits limited to 30 visits/year</td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehabilitation Therapy&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
</tbody>
</table>

<sup>3</sup> Pre-certification required
**Emergency Care**

In a true emergency, go directly to the nearest medical facility. As long as it’s a true emergency, you pay nothing for emergency care, whether it’s from an In-Network or Out-of-Network provider and precertification is not required. However, keep in mind that benefits for treatment in a hospital emergency room are limited to the initial visit for emergency care. An In-Network provider must provide all follow-up care for you to receive maximum benefits. Also remember to contact MedReview within 48 hours after an emergency hospital admission, as described on page 16, to pre-certify any continued stay in the hospital.

To be covered as emergency care, the treatment must be for a condition whose symptoms are so serious that a prudent layperson – who has average knowledge of health and medicine – could reasonably expect that, without emergency care, any of the following would happen:

- The patient’s health would be placed in serious jeopardy.
- There would be serious problems with the patient’s body functions, organs or parts.
- There would be serious disfigurement.
- The patient or those around him/her would be placed in serious jeopardy, in the event of a behavioral health emergency.

Severe chest pains, extensive bleeding and seizures are examples of emergency conditions.

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<table>
<thead>
<tr>
<th>Provision</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Therapy³</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Emergency Room Care</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>

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³ Pre-certification required

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If you have an emergency while outside the Empire BlueCross BlueShield operating area of 28 eastern New York State counties (Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester), be sure to show your Empire ID card at the emergency room. If the hospital participates with another BlueCross and/or BlueShield plan in the BlueCard® PPO program, your claim will be processed by the local BlueCross and/or BlueShield plan. If you have an emergency outside the United States and visit a hospital which participates in the BlueCard® Worldwide Program, simply show your Empire ID card. The hospital will submit its bill through the BlueCard Worldwide Program. If the hospital does not participate with the Blue Card Worldwide Program, you will need to file a claim in order to be reimbursed for your eligible expenses.

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**Urgent care.** Sometimes, you have a need for urgent care, which is medical care that is not an emergency but is still so serious that you can’t wait for a regular appointment. For example, you may need urgent care when you have a severe cough, an unexplained high fever or a sprained ankle. If you need urgent care, call your physician or your physician’s backup (that is, the physician on call if your physician isn’t available).
Inpatient Hospital Care

The Plan covers all necessary hospital services and supplies, including (but not limited to) the following:

- Semi-private room and board when:
  - The patient is under the care of a physician, and
  - A hospital stay is medically necessary.

If you request a private room when it’s not medically necessary for you to have one, benefits will be limited to the average charge for a semi-private room.

- Operating and recovery rooms
- Special diet and nutritional services while in the hospital
- Cardiac care unit
- Services of a licensed physician or surgeon employed by the hospital (if their services are included in hospital charges)
- Care related to surgery
- Breast cancer surgery (lumpectomy, mastectomy), including reconstruction following surgery, surgery on the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications at any stage of a mastectomy, including lymphedemas (the patient has the right to decide, in consultation with the physician, the length of hospital stay following mastectomy surgery)
- Use of cardiographic equipment
- Drugs, dressings and other medically necessary supplies
- Social, psychological and pastoral services
- Reconstructive surgery associated with injuries unrelated to cosmetic surgery
- Reconstructive surgery for a functional defect that is present from birth
- Inpatient physical, occupational, speech or vision therapy, including facilities, services, supplies and equipment
- Chemotherapy and radiation
- Facilities, services, supplies and equipment related to medically necessary care.

Ambulatory Services

You are also covered for the following same-day (outpatient or ambulatory) hospital services and supplies:

- Same-day surgery (see below), including hospital outpatient surgical facilities, surgeons and surgical assistants
- Blood and blood derivatives
- For emergency care, ambulatory surgery
- Cervical cancer screenings, including a pelvic examination, pap smear and diagnostic services in connection with evaluating the pap smear
- Mammogram (based on age and medical history).
  - Ages 35 through 39 – 1 baseline
  - Age 40 and older – 1 per year
- Chemotherapy and radiation therapy, including medications, in a hospital outpatient department, doctor’s office or facility (medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy)

If you're traveling outside the United States and have to go to the hospital, you should know that the BlueCard Worldwide Program provides hospital and professional coverage through an international network of health care providers. With this program, you're assured of receiving care from licensed providers. The program also assures that at least one staff member at the hospital will speak English, or the program will provide translation assistance. Here's how to use Blue Card Worldwide:

- Call (800) 634-673-1177, 24 hours a day, seven days a week, for the names of participating hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct® Access Number.
- Show your Empire BlueCross BlueShield ID card at the hospital. If you are admitted, you will only have to pay for expenses not covered by your contract, such as copayments, coinsurance, and personal items. Remember to call Empire within 24 hours or as soon as reasonably possible.
- If you receive outpatient hospital care in the BlueCard Worldwide Program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the health care provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. You will receive reimbursement less any copayment and amount above the allowed amount.
Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in the following settings until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare:

- At home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered)

- In a hospital-based or free-standing facility, as defined in the “Key Terms and Definitions” (on page 93).

Same-day surgical services or invasive diagnostic procedures are covered when they meet all of the following requirements:

- They are performed in a same-day or hospital outpatient surgical facility
- They require the use of both surgical operating and postoperative recovery rooms
- They may require either local or general anesthesia
- They do not require an inpatient hospital admission because it is not appropriate or medically necessary
- They would justify an inpatient hospital admission in the absence of a same-day surgery program.

**Pre-surgical testing.** Pre-surgical testing is covered as long as it meets both of these requirements:

- It is performed, preferably, within seven days prior to approved surgery at the same hospital where the surgery will be performed.
- The patient has a reservation for both a hospital bed and operating room (or operating room only if the surgery will be ambulatory surgery).

**Pregnancy and Maternity Care**

The Plan covers services and supplies for maternity and newborn care. Hospital stays for obstetrical care are covered for up to 48 hours after a normal vaginal birth and up to 96 hours after birth by cesarean section. The Plan covers:

- One home care visit if the mother decides to leave before the 48-hour/96-hour period described above, as long as the mother requests the visit from the hospital or a home health care agency within the 48-hour/96-hour period. The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later
- The services of a certified nurse/midwife affiliated with a licensed facility and provided under a physician’s direction
- Parent education, and assistance and training in breast or bottle feeding, if available
- Circumcision of newborn males
- Special care for the baby if the baby needs to stay in the hospital longer than the mother.

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

**Skilled Nursing Facilities**

Skilled nursing facilities are sometimes recommended when you don’t need the extensive care a hospital provides but you’re not well enough to recover at home. The Plan covers inpatient care in a skilled nursing facility, for up to 60 days of inpatient care per person per year. However, you must use an In-Network facility and your doctor must provide all of the following:

- A referral and written treatment plan
- A projected length of stay
- An explanation of the services the patient needs and the intended benefits of care.

Care must be provided under the direct supervision of a physician, registered nurse, physical therapist or other health care professional.
Hospice Care for the Terminally Ill

Patients who have been certified by their physician as having a life expectancy of six months or less often rely on hospice care to help them through the last phases of incurable disease. Up to 210 days of hospice care is covered. The Plan covers hospice services which can be provided in a hospice, in the hospice area of a participating hospital, or at home, as long as it is provided by a participating hospice agency. Hospice care services include:

- Up to 12 hours a day of intermittent nursing care by an RN or LPN
- Medical care by the hospice doctor
- Drugs and medications prescribed by the patient’s doctor that are not experimental and are approved for use by the most recent “Physicians’ Desk Reference”
- Approved drugs and medications
- Physical, occupational, speech and respiratory therapy when required to control symptoms
- Lab tests, X-rays, chemotherapy and radiation therapy
- Social and counseling services for the patient’s family, including bereavement counseling visits for up to one year following the patient’s death
- Medically necessary transportation between home and hospital or hospice
- Medical supplies and rental of durable medical equipment
- Up to 14 hours of respite care a week.

All periods of care in a hospice care program will be considered related and to have occurred in a single period of care unless separated by at least three consecutive months.

Home Health Care

Home health care services and supplies include nursing care by a registered nurse (RN) or licensed practical nurse (LPN) and home health aid services. We’ll cover up to 200 home health care visits per person per year (In-Network and Out-of-Network combined), as long as your physician certifies that home health care is medically necessary and approves a written treatment plan. One home health care visit by a registered nurse or a physical therapist is considered the same as four hours of home health aid care. Benefits are payable for up to three visits a day. Home health care services include:

- Intermittent or part-time nursing care by an RN or LPN
- Intermittent or part-time home health aid services
- Rehabilitation care: physical, occupational or speech therapy provided by the home health agency
- Medications, medical equipment and medical supplies prescribed by a doctor
- Laboratory services provided by or on behalf of a home health agency to the extent services would be covered if the covered member was in a hospital or a Skilled Nursing Facility as defined by Medicare.

If you use a home health care agency in the Empire Network, the agency is responsible for calling MedReview to pre-certify. If you use an Out-of-Network home health care agency, or one that’s in the BlueCard® PPO Network, you’re responsible for calling; otherwise, a pre-certification penalty may apply.

Home infusion therapy. Home infusion therapy, a service sometimes provided during home health care visits, is available only In-Network. The Network supplier must pre-certify by calling MedReview. If you use a supplier outside Empire’s operating area through the BlueCard® PPO Program, you are responsible for pre-certifying. An Empire Network home health care agency or home infusion supplier may not bill you for covered services. If you receive a bill from one of these providers, contact Empire Member Services.

Physical Therapy

Physical therapy is often recommended to help you get back full function of your body following surgery or inpatient treatment. The Plan covers up to 30 days of inpatient physical therapy per person per year (In-Network and Out-of-Network combined), and an unlimited number of outpatient physical therapy visits per person per year (In-Network only). Physical therapy, physical medicine and rehabilitation services – or any combination of these – on an inpatient or outpatient basis up to the Plan maximums are covered as long as the treatment is prescribed by your physician and designed to improve or restore physical functioning within a reasonable period of time. If you receive therapy on an inpatient basis, it must be short-term; if it’s on an outpatient basis, you must receive it through an In-Network therapist’s office or approved facility. Up to 30 visits a year are covered for outpatient physical therapy.
KEEPPING UP WiTH THe LaTEST MeDICAL TECHNOLOGY

Modern medicine is always developing new ways to treat illness and injury. The Plan, through Empire, relies on a committee of doctors to keep up with the latest advances in medicine and decide whether new equipment and/or procedures should be covered by the Plan. If you want to ask the committee to consider a new medical technology or treatment before treatment starts, have your provider contact the Empire. The provider will be asked to do the following:

- Provide full supporting documentation about the new medical technology
- Explain how standard medical treatment has been ineffective or would be medically inappropriate
- Send the committee scientific peer-reviewed literature that supports the effectiveness of this particular technology (the literature must not be in the form of an abstract or individual case study).

The Plan will have Empire review the proposal, taking into account our contract, Empire’s current medical policy and relevant medical literature, and current peer-reviewed articles and reviews. Empire may use outside consultants, if necessary. If the request is complicated, Empire may refer your proposal to a multi-specialty team of physicians or to a national ombudsman program designed to review such proposals. Empire will then notify you, your doctor and the Fund Office of Empire’s decision.

Occupational, Speech or Vision Therapy

The Plan covers occupational, speech or vision therapy – or any combination of these – on an outpatient basis up to the Plan maximums as long as the treatment is prescribed by your physician or given together with a physician’s services; given by skilled medical personnel at home, in a therapist’s office or in an approved outpatient facility, speech therapy must be performed by a licensed speech/language pathologist or audiologist. You must receive services through an In-Network therapist’s office or approved facility.

Up to 30 visits a year are covered.

Organ and Tissue Transplants

The Plan offers organ and tissue transplant services through hospitals known as the BlueCross and BlueShield Association’s Blue Quality Centers for Transplant (BQCT). Transplant cases are managed by Empire’s Centers of Excellence (COE) Program, a comprehensive transplant case management program. If you need a transplant, Empire’s COE staff will outline your choices for you and help you and your doctor decide whether to use a BQCT institution or another Network facility. This ensures that you get the highest level of benefits while keeping your out-of-pocket expenses down. If you need more information about COE or BQCT, contact Empire.

Note: All hospital benefits are administered by Empire BlueCross BlueShield. Empire has exclusive authority and discretion to award benefits. Accordingly, Empire BlueCross BlueShield determines which medical services you receive are eligible for benefits payment.
The MagnaCare Preferred Provider Organization (PPO) is a network of doctors and other health care providers and facilities selected by MagnaCare to provide medical benefits to Plan participants.

When You Go In-Network
In-Network benefits apply only to services and supplies that are both covered by the Plan and provided or authorized by a MagnaCare PPO Network provider. The Network provider will assess your medical needs and advise you on appropriate care, as well as take care of any necessary paperwork or administrative requirements. When you use a doctor or other provider in the Network, the Plan will pay 100% of the cost of your eligible expenses (subject to Plan limits). You will not have to satisfy a deductible — you will pay only a $10 copayment for doctor visits and certain other services and supplies (such as outpatient physical therapy or chiropractic care).

Note: If services are received in an In-Network hospital but the pathologist, radiologist, anesthesiologist or emergency room doctor is an Out-of-Network provider, the Out-of-Network deductible will be waived, but you will be responsible for the applicable coinsurance and the claim will be paid at the In-Network benefit level up to the reasonable and customary amount. You will be responsible for amounts above the reasonable and customary amount. To be paid at the In-Network level, you must have made every effort to use In-Network providers.

When you use an In-Network provider, you are getting your expenses covered at the highest level. What's more, there are no deductibles or coinsurance to pay, and no claims to file or keep track of.

Selection of a Primary Care Provider
Your plan allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.magnacare.com or contact customer service at (800) 352-6465.

Direct Access to Obstetricians and Gynecologists
You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain
procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.magnacare.com or contact customer service at (800) 352-6465.

When You Go Out-Of-Network

Care that is not provided by an In-Network provider is considered Out-of-Network care and, as such, reimbursed at a lower level. If you use Out-of-Network providers, you must first satisfy the annual deductible before being reimbursed a percentage of the allowed amount. Amounts above the allowed amount are NOT eligible for reimbursement and are your responsibility to pay, in addition to any deductibles and required coinsurance. For this reason, you may want to ask your doctor if he/she will accept MagnaCare’s payment as payment in full (excluding your deductible or coinsurance requirements).

When you visit Out-of-Network providers, they may tell you they take “Local 30” or “MagnaCare” coverage, but you will still pay more for your care. MagnaCare sets a maximum dollar amount it covers for Out-of-Network services. This maximum is called the “reasonable and customary” or “allowed” amount. You are responsible for paying EVERY DOLLAR of the cost that is ABOVE the reasonable and customary amount. You pay this extra cost IN ADDITION to the deductible and coinsurance.

Annual deductible. Each participant must satisfy the $100 individual annual deductible before benefits become payable for Out-of-Network care. However, if you have family coverage, the annual deductible obligation is considered met once two family members each have $100 of eligible expenses (for a total of $200). Please note that if you incur any expenses that are applied to a deductible during the last three months of the calendar year, these amounts will also be applied to meet the next calendar year’s deductible.

The following expenses are not applied toward the Out-of-Network annual deductible:

- In-Network copayments
- Charges that exceed the allowed amount for eligible Out-of-Network expenses
- Charges that exceed Plan limits
- Charges for services excluded by the Plan (see page 31).

Coinsurance. Once the annual deductible is met, the Plan pays 80% of the allowed amount for eligible Out-of-Network expenses. You pay the remaining 20%, which is your coinsurance. You also pay any amounts over the allowed amount. Keep in mind that there is no coverage for any service or supply that is not considered medically necessary.

Annual out-of-pocket maximum. The annual out-of-pocket maximum puts a cap on the coinsurance each participant has to pay in a given calendar year. Your 20% coinsurance is limited each year to $500 per person. Any eligible expenses submitted for reimbursement after the annual out-of-pocket maximum is reached are paid at 100% of the allowed amount.

The following expenses are not applied toward the Out-of-Network annual out-of-pocket maximum:

- Out-of-Network deductibles
- In-Network copayments
- Charges that exceed the allowed amount for eligible Out-of-Network expenses
- Charges that exceed Plan limits
- Charges for services excluded by the Plan (see page 31).

The fact that an In-Network provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it medically necessary. If you have questions about what is and isn’t medically necessary or what is not covered by the Plan, contact the MagnaCare’s Customer Service Department at (800) 352-6465. You are responsible for verifying if any particular medical service is covered by the Plan.

Benefit Maximums

There is no lifetime medical benefit maximum. There may be limits on how much (and how often) the Plan will pay for certain expenses, even when they’re covered. If there are limits on a particular expense, it will be spelled out where a covered service is explained (in the next section of this booklet).
# Overview of Eligible MagnaCare Expenses

<table>
<thead>
<tr>
<th>Provision</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>How You Access Care</td>
<td>Go to any Network provider.</td>
<td>Go to any licensed/certified provider who does not participate with MagnaCare.</td>
</tr>
<tr>
<td>Basis for Reimbursement</td>
<td>All In-Network reimbursements are based on the allowed amount for medically necessary eligible expenses. In-Network providers have agreed to accept the allowed amount as payment in full (minus any applicable per-visit copayments you pay directly to the provider).</td>
<td>All Out-of-Network reimbursements are based on the allowed amount for medically necessary eligible expenses and subject to the deductible and coinsurance. Out-of-Network providers may or may not accept MagnaCare’s payment as payment in full (excluding deductibles and coinsurance); if they don’t, you are responsible for paying every dollar of the excess.</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- individual</td>
<td>Not applicable</td>
<td>$100</td>
</tr>
<tr>
<td>- family</td>
<td></td>
<td>$200</td>
</tr>
<tr>
<td>Copayments (where applicable)</td>
<td>$10/visit</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Coinsurance (where applicable)</td>
<td>Plan pays 100%</td>
<td>Plan pays 80% of the allowed amount</td>
</tr>
<tr>
<td>Annual Coinsurance Maximum</td>
<td>Not applicable</td>
<td>$500/person</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>

## General Medical Care

<table>
<thead>
<tr>
<th>Provision</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
<td>Plan pays 100% of the costs incurred for preventative services.</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td></td>
<td>$10 copay per visit applies to sick visits</td>
<td></td>
</tr>
<tr>
<td>Specialist visits</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Chiropractic visits</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount up to $125</td>
</tr>
<tr>
<td>(spinal manipulation only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Manipulation Covered Only</td>
<td>Maximum of 36 visits per year (precertification is required after the 10th visit)</td>
<td></td>
</tr>
<tr>
<td>Acupuncture (administered by a medical doctor (M.D.) only)</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Second surgical opinion</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Outpatient Diabetes education and management</td>
<td>$10 copay per visit.</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Provision</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Allergy care</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Dermatology</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Diagnostic procedures:</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount.</td>
</tr>
<tr>
<td>• X-rays and other imaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MRIs/MRAs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• All lab tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery (surgeon’s fees)</td>
<td>Plan pays 100%, no copay required</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>Plan pays 100%, no copay required</td>
<td>Plan pays up to $125 per unit. You will be responsible for charges over the allowance.</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered under BCBS – see page 19.</td>
<td></td>
</tr>
<tr>
<td>X-ray, radium and radionuclide therapy</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Maternity Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits for prenatal and postnatal care</td>
<td>$10 copay for first visit only (i.e., one copay per pregnancy)</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Diagnostic procedures:</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>• Sonograms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lab tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other diagnostic procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual physical exam</td>
<td>Plan pays 100%, no copay required</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Diagnostic screening tests:</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>• Cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Colorectal cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine PSA tests in asymptomatic males</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td>Provision</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Preventive care</td>
<td>Plan pays 100%, no copay required</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount, up to a $200 annual maximum benefit</td>
</tr>
<tr>
<td>Well-woman care:</td>
<td>Plan pays 100%, no copay required</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount, up to a $200 annual maximum benefit</td>
</tr>
<tr>
<td>■ Office visits (includes Pap smears and urinalysis)</td>
<td>Plan pays 100%, no copay required</td>
<td>Plan pays 100%, after $10 copay</td>
</tr>
<tr>
<td>■ Mammogram (one preventive mammogram per year for women age 35 and older; not combined with preventive and well-woman exams)</td>
<td>Plan pays 100%, no copay required</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount, up to a $200 annual maximum benefit</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV) vaccine</td>
<td>Plan pays 100%, no copay required, for an office visit and three injections for women up to age 30</td>
<td>Plan pays 100%, no copay required, for an office visit and three injections for women up to age 30</td>
</tr>
<tr>
<td>Well-child care for children up to age 19, including immunizations, office visits and associated lab services provided within 5 days of office visit</td>
<td>Plan pays 100%, no copay required</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount, up to a $140 annual maximum benefit for ages 4-18</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Plan pays 100%, no copay required</td>
<td>Plan pays 100% of the allowed amount, no copay required</td>
</tr>
<tr>
<td>■ Emergency room – Physician only (care must be received within 72 hours of an accidental injury or within 12 hours of the onset of sudden, serious illness)</td>
<td>Plan pays 100%, no copay required</td>
<td>Plan pays 100% of the allowed amount, no copay required</td>
</tr>
<tr>
<td>■ Ambulance (local professional ground ambulance to the nearest hospital or air ambulance to nearest acute care hospital for emergency or inpatient admissions)</td>
<td>Plan pays 100%, no copay required</td>
<td>Plan pays 100% of the allowed amount, no copay required. You are responsible for the deductible and coinsurance, as well for any charges above the allowed amount.</td>
</tr>
<tr>
<td>Other Eligible Medical Expenses</td>
<td>Plan pays 100%, no copay required</td>
<td>Plan pays 100%, no copay required, for an office visit and three injections for women up to age 30</td>
</tr>
<tr>
<td>■ Outpatient care</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount, up to a $140 annual maximum benefit for ages 4-18</td>
</tr>
<tr>
<td>■ Same-day surgery</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount, up to a $140 annual maximum benefit for ages 4-18</td>
</tr>
<tr>
<td>■ Pre-surgical testing</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount, up to a $140 annual maximum benefit for ages 4-18</td>
</tr>
<tr>
<td>■ Infertility treatment (including assisted reproductive technology procedures such as in-vitro fertilization)</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount, up to a $140 annual maximum benefit for ages 4-18</td>
</tr>
</tbody>
</table>

**NOTE:** This $10,000 lifetime maximum benefit does not include drugs prescribed as part of the infertility treatment, which are subject to a separate and additional $10,000 lifetime maximum benefit.
<table>
<thead>
<tr>
<th>Provision</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Durable medical equipment</strong> (such as wheelchairs and hospital beds)</td>
<td>Plan pays 100%, no copay required</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If cost is above $500, precertification required</td>
</tr>
<tr>
<td><strong>Outpatient Rehabilitation</strong> (physical, occupational, speech therapy)</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount up to $125</td>
</tr>
<tr>
<td></td>
<td>Speech therapy is covered for all diagnoses if prescribed by physician with review required after 10 visits.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Must be reviewed after 20 visits and treatment plan is requested prior to treatment.</td>
</tr>
<tr>
<td><strong>Private Duty Nursing</strong> (performed by a registered graduate nurse or a licensed practical nurse)</td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benefits limited to 200 visits/year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered within 7 days of discharge</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health Treatment</strong></td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
<tr>
<td><strong>Outpatient Substance Abuse Treatment</strong></td>
<td>$10 copay per visit</td>
<td>After you pay the deductible, Plan pays 80% of the allowed amount up to $130 per visit until you reach the coinsurance maximum; then, Plan pays 100% of the allowed amount</td>
</tr>
</tbody>
</table>

**General Medical Care**

Everyone needs to see a doctor from time to time for colds, headaches, back pain and other common ailments. When you do, just call your MagnaCare PPO Network doctor’s office for an appointment. Make sure you have your MagnaCare ID card with you when you go.

The Plan covers physicians’ services – both generalists and specialists – received in a physician’s office or at home to treat a specific illness or injury, and also covers related services of other approved providers (such as labs). In addition to the services and supplies listed on the chart on page 26, the Plan covers:

- The services of a certified nurse-midwife
- Home dialysis treatment, as well as the reasonable rental cost of the required equipment
- Dialysis in a hospital or freestanding facility, if the facility’s dialysis program is approved by the appropriate government authorities
- Diabetes supplies prescribed by an authorized provider (such as blood glucose monitors, testing strips and syringes)
- Diabetes self-management education and diet information
- Services related to treatment of cerebral palsy
- Wigs for cancer chemotherapy patients where hair loss is anticipated only; does not include non-chemotherapy-related hair loss due to androgenetic alopecia, trichotillomania, traction alopecia and medication, up to a $500 maximum.
- Hearing exams.
**Specialists.** You have access to a wide range of medical specialists through the MagnaCare PPO Network. If you want to see a specialist, you don’t need a referral; just contact the doctor directly.

**Preventive Care**

It’s a good idea to get a routine physical exam once a year. At your checkup, take the recommended tests to help identify illness or the risk of serious illness. The Plan covers routine physicals for all participants, subject to limits shown on the chart on page 28.

Eligible expenses include X-rays, laboratory or other tests given in connection with the exam and materials for the administration of immunizations for infectious diseases. Here are some other things you may need to know about preventive care.

- Well-woman care consists of routine visits to an obstetrician/gynecologist. An annual or biannual gynecological exam may be performed by an obstetrician/gynecologist or the patient’s Primary Care Physician. All women are strongly encouraged to see their gynecologist regularly for Pap smears and mammograms.

- Well-child care visits can be to a pediatrician, family practice doctor, nurse or licensed nurse practitioner.

- Regular checkups may include a physical examination, medical history review, developmental assessment, guidance on normal childhood development and laboratory tests. The tests may be performed in the office or a laboratory. The number of well-child visits covered per year depends on your child’s age, as shown in the chart on page 28.

  - Well-child care immunizations include:
    - Diphtheria, tetanus and pertussis (DtaP)
    - Hepatitis B
    - Haemophilus influenza Type B (Hib)
    - Pneumococcus (Pcv)
    - Polio (IPV)
    - Measles, mumps and rubella (MMR)
    - Varicella (chicken pox)
    - Tetanus-diphtheria (Td)
    - Hepatitis A and influenza for certain patients
    - Other immunizations as determined by the American Academy of Pediatrics, Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives.

  - Adults, teens and children are covered for the above immunizations as medically necessary.

- The Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010 for the following services:
  - Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,
  - Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and
  - Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines.

- In-Network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the participant or dependent. This means that the service will be covered at 100% of the Plan’s allowable charge, with no coinsurance, copayment, or deductible.

- In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

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**Get Fit – Stay Healthy (For Active Members Only)**

As an active member (no spouses or Dependents), you will be eligible to receive partial reimbursement of up to a maximum of $200 per calendar year when you join an exercise facility that maintains equipment and programs promoting cardiovascular wellness and you complete 50 visits within a six-month period.
Durable Medical Equipment and Supplies

The Plan covers buying, renting and/or repairing prosthetics (such as artificial limbs), orthotics and other durable medical equipment and supplies. If the cost is above $500, precertification is required by providing the Fund Office with a letter from your provider stating the medical necessity of the equipment and supplies. The Plan covers:

- Artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses
- Supportive devices essential to the use of an artificial limb
- Corrective braces
- Diabetic supplies
- Wheelchairs, hospital-type beds, oxygen equipment and sleep apnea monitors
- Replacement of covered medical equipment because of wear, damage, growth or change in patient’s need, when ordered by a physician
- Reasonable cost of repairs and maintenance for covered medical equipment.

The Plan will cover the cost of buying equipment when the purchase price is expected to be less costly than long-term rental, or when the item is not available on a rental basis.

What’s Not Covered by the PPO Medical Plan (BCBS Hospital and MagnaCare)

The PPO Medical Plan will not reimburse or make payments for expenses incurred for, caused by, or resulting from:

- Medically unnecessary treatment
- Injury or sickness that arises out of, or in the course of, any occupation or employment for wage or profit for which there is Workers’ Compensation or occupational disease law coverage
- Any treatment covered under another insurance plan, except as provided for under Coordination of Benefits (see page 84)
- War, or any act of war (declared or undeclared) or military service of any country
- Blood and blood products, if a voluntary program exists
- A criminal act by the enrolled person, or a self-inflicted injury
- Cosmetic treatment that’s not considered medically necessary. Cosmetic treatment will be considered not medically necessary unless the treatment is necessitated by injury, is for breast reconstruction after cancer surgery, or is necessary to lessen a disfiguring disease or a deformity arising from or directly related to a congenital abnormality. For this purpose, cosmetic treatment includes any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- Dental treatment, except surgical removal of impacted teeth or treatment of sound natural teeth injured by accident if treated within 12 months of the injury. However, see “Dental Benefits,” page 46, to find out how dental expenses may be covered.
- Expenses for services or supplies for which a participant receives payment or reimbursement as a result of legal action or settlement (for information about subrogation of benefits, see page 85)
- Expenses reimbursable under the “no-fault” provisions of a state law
- Confinement in a hospital owned or operated by a state, province, or political subdivision, unless there is an unconditional requirement on the part of the enrolled person to pay such expenses without regard to any liability against others, contractual or other services covered under government programs, except Medicaid or where otherwise noted
- Government hospital services, except:
  - Specific services covered in a special agreement between Empire BlueCross BlueShield and a governmental hospital
  - United States Veterans’ Administration or Department of Defense hospitals, except services in connection with a service-related disability. In an emergency, Empire BlueCross BlueShield will provide benefits until the government hospital can safely transfer the patient to a participating hospital.
- Technology, treatments, procedures, drugs, biological products or medical devices that are experimental, investigative, obsolete or ineffective. Also excluded are any hospitalization in connection with experimental or investigational treatments.
- Treatment or care for temporomandibular disorder, temporomandibular joint disorder (TMJ) syndrome
- Charges incurred while a person is not eligible under the Plan
- Charges that exceed the maximum allowed amount for a service
- Services performed at home, except for those services specifically noted elsewhere in this booklet as available either at home or in an emergency
- Services usually given without charge, even if charges are billed
Services performed by hospital or institutional staff that are billed separately from other hospital or institutional services, except as otherwise specified elsewhere in this booklet

Surgery and/or treatment for gender change

All prescription drugs and over-the-counter drugs, self-administered injectables, vitamins, appetite suppressants, or any other type of medication, unless specifically indicated. However, see “Prescription Drug Benefits,” page 43, to find out how prescription drug expenses may be covered under the prescription drug program.

Elective abortions, except for instances when the life of the mother would be endangered if the fetus were to be carried to term; or if there are complications due to an elective abortion

Reversal of sterilization

Travel expenses, except as specified

Eyeglasses, contact lenses and the examination for their fitting except following cataract surgery. However, see “Optical Care Benefits,” page 60, to find out how eyeglasses and contact lenses may be covered under the Vision program.

The following specific medical services:

- Services such as laboratory, X-ray and imaging, and pharmacy services as required by law from a facility in which the referring physician or his/her immediate family member has a financial interest or relationship
- Services given by an unlicensed provider or performed outside the scope of the provider’s license
- The following specific preventive care services:
  - Screening tests done at your place of work at no cost to you
  - Free screening services offered by a government health department
  - Tests done by a mobile screening unit, unless a doctor not affiliated with the mobile unit prescribes the tests
- The following specific emergency services:
  - Use of the emergency room to treat routine ailments, because you have no regular physician or because it is late at night (and the need for treatment is not sudden and serious)
  - Ambulette
- The following specific maternity care services:
  - Days in hospital that are not medically necessary (beyond the 48-hour/96-hour limits)
  - Private room (if you use a private room, you pay the difference between the cost for the private room and the hospital’s average charge for a semiprivate room. The additional cost cannot be applied to your deductible or coinsurance.)
- The following specific inpatient hospital care expenses:
- The following specific outpatient hospital care expenses:

- Certain same-day surgeries not pre-certified as medically necessary
- Routine medical care, including (but not limited to) inoculation, vaccination, drug administration or injection, excluding chemotherapy
- Collection or storage of your own blood, blood products, semen or bone marrow
- The following specific equipment:

- Air conditioners or purifiers
- Humidifiers or de-humidifiers
- Exercise equipment
Swimming pools
False teeth
Skilled nursing facility care that primarily:
- Gives assistance with daily living activities
- Is for rest or for the aged
- Treats drug addiction or alcoholism
- Is convalescent care
- Is sanitarium-type care
- Is a rest cure
The following specific home health care services:
- Custodial services, including bathing, feeding, changing or other services that do not require skilled care
- Out-of-Network home infusion therapy
The following specific physical, occupational, speech or vision therapy services:
- Therapy to maintain or prevent deterioration of the patient’s current physical abilities
- Tests, evaluations or diagnoses received within the 12 months prior to the doctor’s referral or order for occupational, speech or vision therapy
- Psychological testing for educational purposes for children or adults
- Services of a nutritionist and nutritional therapy or counseling
- Contraceptive devices (see “Prescription Drug Benefits,” page 43, to find out how oral contraceptives may be covered under the prescription drug program)
- Vitamin therapy and non-prescription drugs
- Common first-aid supplies such as adhesive tape, gauze, antiseptics, ace bandages, and surgical appliances that are stock items, such as braces, elastic supports, semi-rigid cervical collars or surgical shoes
- Operating room fees for surgery, surgical trays and sterile packs done in a non-state-licensed facility including the physician’s office
- Expenses incurred prior to the effective date of an individual’s coverage under the Plan
- Expenses for which you have already been reimbursed by a third party who was responsible because of negligence or other tort or wrongful act of that third party (for information about subrogation of benefits, see page 85)
- Expenses for surgical correction of refractive error or refractive keratoplasty procedures including, but not limited, to radial keratotomy (RK) and photorefractive keratotomy (PRK), except for laser eye surgery which is covered. See page 60 for details.
- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, or other physical fitness facilities. See exception to this on page 30.
- Expenses for pre-planned home delivery the following specific podiatry expenses:
  - Foot orthotics
  - Dispensing of surgical shoe(s)
  - Pre- and post-operative X-rays.
- Charges for services a relative provides are not eligible for coverage.
- With respect to any injury excluded or otherwise limited by the Plan, the Plan will not deny benefits provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including physical and mental health conditions).
The CIGNA Open Access Plus In-Network Copay Plan is an Exclusive Provider Organization (EPO) consisting of a network of doctors and other health care providers and facilities selected by CIGNA to provide medical benefits to Plan participants. The CIGNA Open Access Plus In-Network plan provides referral-free access to specialty care. You are encouraged, but are not required, to select a Primary Care Physician (PCP) to coordinate your care.

**When You Go In-Network**

In-Network benefits apply only to services and supplies that are both covered by the Plan and provided or authorized by CIGNA. The Plan will not cover any medical or other expenses that are received from providers who are unauthorized by CIGNA, or Out-of-Network (only emergency and urgent care are covered when received from Out-of-Network health care professionals).

**Prior Authorization**

Participating Provider must receive Prior Authorization from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy. Services that require Prior Authorization include, but are not limited to:

- Inpatient Hospital services;
- Inpatient services at any participating Other Health Care Facility;
- Residential treatment;
- Outpatient facility services;
- Intensive outpatient programs;
- Advanced radiological imaging;
- Non-emergency ambulance; or
- Transplant services.

**Summary of Benefits**

<table>
<thead>
<tr>
<th>Annual Deductibles and Maximums</th>
<th>In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime maximum</td>
<td>Unlimited (per individual)</td>
</tr>
<tr>
<td>Coinsurance and deductible</td>
<td>Plan pays 100%; no deductible</td>
</tr>
</tbody>
</table>
## Benefits

### Physician Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Payment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office visit copay</strong></td>
<td>You pay $25 per visit</td>
</tr>
<tr>
<td>Includes allergy treatment injections</td>
<td></td>
</tr>
<tr>
<td><strong>Physician services (hospital)</strong></td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Includes in hospital visits and consultations</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
</tr>
<tr>
<td><strong>Surgery (in a physician’s office)</strong></td>
<td>You pay $25 per visit</td>
</tr>
</tbody>
</table>

### Preventive Care

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Payment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive care</strong></td>
<td>No charge</td>
</tr>
<tr>
<td>Includes well-baby, well-child, well-woman and adult preventive care</td>
<td></td>
</tr>
<tr>
<td>Includes immunizations</td>
<td></td>
</tr>
<tr>
<td>Includes lab and x-ray billed by the doctor’s office</td>
<td></td>
</tr>
<tr>
<td><strong>Mammogram, PSA, Pap Smear and Maternity Screening</strong></td>
<td>No charge</td>
</tr>
<tr>
<td>Coverage includes the associated Preventive Outpatient Professional Services</td>
<td></td>
</tr>
<tr>
<td>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service</td>
<td></td>
</tr>
</tbody>
</table>

### Inpatient Hospital Facility Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Payment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-private room and board and other non-physician services</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Includes inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc.</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Professional Services</strong></td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>For services performed by surgeons, radiologists, pathologists and anesthesiologists</td>
<td></td>
</tr>
<tr>
<td><strong>Multiple surgical reduction</strong></td>
<td>Included</td>
</tr>
<tr>
<td>Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.</td>
<td></td>
</tr>
</tbody>
</table>

### Outpatient Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Payment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient surgery (facility charges)</strong></td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Non-surgical treatment procedures are not subject to the facility copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Professional Services</strong></td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>For services performed by surgeons, radiologists, pathologists and anesthesiologists</td>
<td></td>
</tr>
<tr>
<td>Service Description</td>
<td>Maximum Days</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Physical, occupational, cognitive and speech therapy</td>
<td>Limited to 60 days</td>
</tr>
<tr>
<td>Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy</td>
<td>Limited to 60 days</td>
</tr>
<tr>
<td>Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short-term rehab therapy maximum.</td>
<td>Limited to 60 days</td>
</tr>
<tr>
<td>Outpatient cardiac rehabilitation</td>
<td>Limited to 36 days</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Limited to 36 days</td>
</tr>
</tbody>
</table>

**Lab and X-ray**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Location</th>
<th>Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab and X-ray</td>
<td>Physician’s office</td>
<td>No charge after the visit copay</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>Outpatient hospital facility</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>Independent x-ray and/or lab facility</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Lab and X-ray, emergency room and urgent care</td>
<td>Emergency room when billed by the facility as part of the emergency room visit</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Lab and X-ray, emergency room and urgent care</td>
<td>Urgent care when billed by the facility as part of the urgent care visit.</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Lab and X-ray, emergency room and urgent care</td>
<td>Independent x-ray and/or lab facility in conjunction with an emergency room visit</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>

**Advanced radiological imaging**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Location</th>
<th>Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.)</td>
<td>Physician’s office visit</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.)</td>
<td>Inpatient facility</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.)</td>
<td>Outpatient facility</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.)</td>
<td>Emergency room</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.)</td>
<td>Urgent care facility</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>

**Emergency and Urgent Care Services**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital emergency room</td>
<td>You pay $100 per visit, then no charge (if the provider is In-Network)</td>
</tr>
<tr>
<td>Including radiology, pathology and physician charges</td>
<td></td>
</tr>
<tr>
<td>Copay waived if admitted, then inpatient hospital charges would apply</td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Note: Non-emergency transportation (e.g. from hospital back home) is generally not covered.</td>
<td></td>
</tr>
<tr>
<td>Urgent care services</td>
<td>You pay $25 per visit</td>
</tr>
<tr>
<td>Copay waived if admitted, then inpatient hospital charges would apply.</td>
<td></td>
</tr>
</tbody>
</table>
### Other Health Care Facilities

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing facility, rehabilitation hospital and other facilities</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>60 days per calendar year</td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Limited to 60 days per calendar year</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>

### Other Health Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable medical equipment and Diabetic Supplies</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Unlimited per calendar year maximum</td>
<td></td>
</tr>
<tr>
<td>External prosthetic appliances (EPA)</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Unlimited per calendar year maximum</td>
<td></td>
</tr>
<tr>
<td>Wigs – Chemo patients only</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>$500 per calendar year maximum</td>
<td></td>
</tr>
<tr>
<td>TMJ</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Infertility</td>
<td></td>
</tr>
<tr>
<td>Office visit for testing, treatment and artificial insemination</td>
<td>If performed in a doctor’s office, you pay $25 copay; If performed in a hospital, Plan pays 100%</td>
</tr>
<tr>
<td>Inpatient hospital facility</td>
<td></td>
</tr>
<tr>
<td>Outpatient hospital facility</td>
<td></td>
</tr>
<tr>
<td>Physician services</td>
<td></td>
</tr>
<tr>
<td>Treatment/Surgery includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.</td>
<td></td>
</tr>
<tr>
<td>$10,000 lifetime maximum (NOTE: This $10,000 lifetime maximum benefit does not include drugs prescribed as part of the infertility treatment, which are subject to a separate and additional $10,000 lifetime maximum benefit)</td>
<td></td>
</tr>
<tr>
<td>Family planning</td>
<td></td>
</tr>
<tr>
<td>Includes coverage for surgical sterilization procedures for vasectomy and tubal ligations only (excludes reversals)</td>
<td>If performed in a doctor’s office, you pay $25 copay; If performed in a hospital, Plan pays 100%</td>
</tr>
<tr>
<td>Contraceptive devices covered</td>
<td></td>
</tr>
<tr>
<td>Diabetic supplies</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Includes coverage for pumps, testing strips, lancet and syringes</td>
<td></td>
</tr>
</tbody>
</table>

### Mental health and substance abuse services

Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration:

- Substance Abuse includes Alcohol and Drug Abuse services
- Transition of Care benefits are provided for a 90-day time period

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient mental health services</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Unlimited days per calendar year</td>
<td></td>
</tr>
<tr>
<td>Mental health services are paid at 100% after you reach your out-of-pocket maximum</td>
<td></td>
</tr>
</tbody>
</table>
Exclusions

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren’t limited to):

- Services provided through government programs
- Services that aren’t medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit including services covered by Worker’s Compensation benefits

- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Reversal of sterilization procedures
- Genetic screenings
- Non-prescription and anti-obesity drugs
- Custodial and other non-skilled services
- Weight loss programs
- Hearing aids
- Acupuncture
- Treatment of sexual dysfunction
- Travel immunizations
- Telephone, email and internet consultations in the absence of a specific benefit
- Eyeglass lenses and frames, contact lenses and surgical vision correction (see page 60 for Optical benefits)
### Additional Information

<table>
<thead>
<tr>
<th>Additional Benefit Information</th>
<th>In-Network</th>
</tr>
</thead>
</table>
| **Mental Health/Substance Abuse (MH/SA) Service**<br>**Specific Administration** | Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs:  
- **Partial Hospitalization**: The coinsurance level for partial hospitalization services is the same as the coinsurance level for inpatient MH/SA services.  
- **Standard for Residential Treatment**: Subject to the Plan’s inpatient MH/SA benefit. Coverage only if approved through CIGNA Behavioral Health Case Management.  
- **Intensive Outpatient Program (IOP)**: Benefit is the same as outpatient visits. Coverage only if approved through CIGNA Behavioral Health Case Management.  |
| **Allergy treatment/injections** | No charge after either the PCP or Specialist per office visit copay or the actual charge, whichever is less |
| **Allergy serum (dispensed by the physician in the office)** | No charge |
| **Bereavement counseling – inpatient services** | Paid the same as Inpatient Hospice Facility |
| **Bereavement counseling – outpatient services** | Paid the same as Outpatient Hospice Facility |
| **Maternity care services** | If performed in a doctor’s office, you pay $25 copay; If performed in a hospital, you pay 0%, Plan pays 100% |
| **Organ transplant**<br>- 100% at Lifesource center after plan’s $0 inpatient per admission copay, otherwise same as plan’s Inpatient Hospital Facility benefit<br>- Outpatient 100% at Lifesource center; otherwise 100%<br>- Travel maximum $10,000 per transplant (only available if using Lifesource facility) | If performed in a doctor’s office, you pay $25 copay; If performed in a hospital, you pay 0%, Plan pays 100% |
| **Routine foot disorders** | Not Covered |
Exclusions

What’s Not Covered (not all-inclusive):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren’t limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury which is due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the “Clinical Trials” section of “Covered Services and Supplies;” or the subject of an ongoing phase I, II or III clinical trial, except as provided in the “Clinical Trials” section of “Covered Services and Supplies.”
- Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
- For medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
- Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under “Covered Services and Supplies.”
- Infertility services when the infertility is caused by or related to voluntary sterilization; donor charges and services; cryopreservation of donor sperm and eggs; gestational carriers and surrogate parenting arrangements; and any experimental, investigational or unproven infertility procedures or therapies.
Exclusions

- Reversal of male and female voluntary sterilization procedures.
- Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
- Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
- Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Inpatient Hospital Services,” “Outpatient Facility Services,” “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of “Covered Services and Supplies.”
- Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of “Covered Services and Supplies.”
- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
- Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures.
- Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
- Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in “Covered Services and Supplies.”
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
- Dental implants for any condition.
Selection of a Primary Care Provider

Your plan allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Exclusions

- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
- Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his or her Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.
- Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan.
- Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail & Internet consultations and telemedicine.
- Massage Therapy.
- With respect to any injury excluded or otherwise limited by the Plan, the Plan will not deny benefits provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including physical and mental health conditions).

Note: All CIGNA Open Access Plus benefits are provided by the EPO and there are no benefits payable from any other source. CIGNA has exclusive authority and discretion to award benefits. Accordingly, you will not receive a benefit unless the EPO determines that you are eligible. A detailed description of the benefit, including limitations and exclusions, and claims and appeals is contained within the CIGNA member handbook, which will be provided to you upon request. If there are any discrepancies between the information contained in this Summary Plan Description and the CIGNA member handbook, the CIGNA member handbook will govern.
Your prescription drug benefits are administered by CVS Caremark. There are two ways to get your prescriptions filled: at a participating pharmacy or through a convenient Mail Order Program.

A “generic” drug is a prescription drug that is not under patent protection any longer, which means that any drug manufacturer can make it. It has the same chemical formula, same strength, and generally works as well as a comparable brand-name drug, but is much less costly than the brand-name drug.

At the Pharmacy
To get prescription drug benefits at a retail pharmacy, go to a participating pharmacy to have your prescription filled and show your prescription drug ID card. All national chain and most independently owned drugstores accept your prescription drug card. All prescriptions filled at a participating pharmacy provide you with up to a 30-day supply. You pay 30% of the cost of your prescription, with a $10 minimum payment per prescription and a $25 minimum payment per brand prescription. If you fill your prescription with a brand-name drug when a generic version is available, you pay 30% plus the difference in cost between the generic and the brand-name drug.

If you have a chronic condition and you need to take the same medication for more than 30 days, use the CVS Caremark Mail Order Program or CVS Caremark Maintenance Choice.

There will be no copays for certain drugs and devices that are considered women’s preventive services, including contraception methods.

If your prescription is for a maintenance drug (medication taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes or asthma), you should use the Mail Order Program after two prescription refills.

Call CVS Caremark at (800) 966-5772 to locate a participating pharmacy near you. A participating pharmacy listing will be provided to you free of charge upon request to the Fund Office.

Through Mail Order
The Mail Order Program is designed for those who take maintenance medications. You pay a copayment of 30% with a $10 minimum for generics and a $25 minimum for all brands. If the actual cost of the prescription is less than the minimum copayment, you will only be charged the actual cost for the prescription.

Filling your prescription by mail. Follow these steps to fill mail-order prescriptions.

- When your doctor prescribes a maintenance drug, ask to have the prescription written for up to a three-month supply. If you need medicine at once, ask your doctor to write two prescriptions – one for you to fill right away at your local retail pharmacy, and a second to send to the mail-order pharmacy for a long-term supply. During this initial three-month period, you and your doctor will be able to determine if this maintenance drug works for you and does not need to be changed.

- For your first order, complete the Mail Service Order Form, which you can get from the Fund Office. Be sure to complete as much of the information requested as possible. It is in your best interest to provide any allergy or history information so that the pharmacist will be aware of any potential drug conflict. Complete the Mail Service Order Form for each new prescription. Or, you may call FastStart at (800) 875-0867 to enroll in CVS Caremark’s mail service program.
Enclose your maintenance drug prescription, the Mail Service Order Form, and your payment in the pre-addressed mail service envelope. Your medications are delivered to you at home postage-paid by United Parcel Service or by U.S. mail. Allow 10 to 14 days after the prescription is filled for delivery of your medicine.

A new order form and envelope will be sent to you with each delivery. These forms are also available from the Fund Office.

If you have any questions on the above or about your prescription, please call CVS Caremark. You can order refills by phone (call CVS Caremark customer service toll-free at the number on the back of your prescription card) or from the CVS Caremark website (www.caremark.com). Have your prescription number and credit card ready when you call or log on.

Refills are not shipped automatically. If you have remaining refills on your original prescription, request your CVS Caremark refill three weeks before you need it to avoid running out of medication. You should receive your refill within a week.

Prescriptions for medicines not available through the mail (such as narcotics) will be returned to you.

**CVS Caremark Maintenance Choice.**
Maintenance Choice offers you choice and savings when it comes to filling long-term prescriptions. Now you will be able to get your maintenance prescriptions through the mail (through the CVS Caremark Mail Order Program) or pick them up at any CVS pharmacy. For drugs that you do not take on an ongoing basis (30-day supply), you will continue to use your drug benefit card at any participating pharmacy.

If you are already receiving your maintenance prescriptions through the mail and wish to continue to use mail service, you don’t have to do anything. CVS Caremark will continue to send your medications to your location of choice.

To pick up your 90-day supply at a CVS pharmacy you need to let CVS Caremark know. You can do so quickly and easily by choosing the option that works best for you:

- Register or log into www.caremark.com to select a CVS pharmacy location for pick-up
- Visit your local CVS pharmacy and talk to the pharmacist
- Call CVS Caremark using toll-free using the number on the back of your Prescription Card.

**Specialty Drug Management Program**
Specialty pharmacy is a unique service designed to help people manage complex conditions and their associated treatments. Medicines handled by a specialty pharmacy may be:

- Injectable and infused
- High-cost
- Have special delivery and storage requirements; for example, they need refrigeration.

For more information on what drugs are subject to the Specialty Drug management Program, or if you have questions about the Program, please visit www.cvscaremarkspecialtyrx.com or call (800) 237-2767 from 7:30 a.m. to 9 p.m. Monday through Friday.

**If You Use an Out-of-Network Pharmacy**
If you have your prescription filled at a pharmacy or through a mail order service not affiliated with CVS Caremark, you must submit a claim form and your receipt to CVS Caremark. CVS Caremark will reimburse some of your out-of-pocket expenses, depending on your prescription. For assistance in calculating your reimbursement, please contact the Fund Office. Please keep in mind that you should submit all prescription drug claims for payment within one year of the date your prescription was filled.

**Annual Maximum Benefit**
There is no annual maximum on prescription drug benefits.

**Eligible Drugs**
The following drugs are covered under the Plan:

- Drugs for preventive care (such as aspirin, iron supplements and folic acid), according to United States Prevention Task Force (USPTF) limits.
- Tobacco cessation drugs and products, according to USPTF limits.
- Non-injectable legend drugs (except for those included in the list of medications not covered by the Plan).
- Insulin, including insulin pumps.
- Infertility drugs ($10,000 lifetime maximum benefit).
- Tretinoin topical (e.g., Retin-A), for individuals up to the age of 25.
- Compounded medication, which has a legend drug for at least one ingredient.
- Contraceptives or birth control devices that are not considered women’s preventive services.
- Viagra, up to six pills per month for a period of six months.

- Any other drug that, under the applicable state law, may only be dispensed upon the written prescription of a physician or other lawful provider.

Some medications are covered only if your physician provides a diagnosis code for the pharmacy. Certain other medications can be dispensed in no more than specified quantities unless a letter of necessity is provided.

The Plan covers generic Proton Pump Inhibitor (PPI) drugs that are used to treat GERD or acid reflux but does not cover brand-name PPI drugs. Ask your doctor if a generic PPI drug can be prescribed for you.

**Ineligible Drugs**

The following drugs and drug-related charges are not covered under the Plan:

- Anorectics (any drug used for the purpose of weight loss).

- Anti-wrinkle agents (e.g., Remova®).

- Dermatologicals.

- Hair-growth stimulants.

- Growth hormones.

- Immunization agents.

- Blood or blood plasma.

- Injectable drugs (except insulin).

- Norplant (Levonorgestrel).

- Non-legend drugs (other than insulin).

- Tretinoin topical (e.g., Retin-A) for individuals age 26 and older.

- Therapeutic devices or appliances, regardless of intended use, including:
  - Needles
  - Syringes
  - Support garments
  - Other non-medical substances.

- Drugs labeled “Caution: limited by federal law to investigative use,” or experimental drugs, even though a charge is made to the individual.

- Charges for the administration or injection of any drug.

- Any medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution, which operates, or allows the operation of a facility for dispensing pharmaceuticals on its premises.

- Brand-name Proton Pump Inhibitor (PPI) drugs including:
  - Nexium
  - Prevacid
  - Prevacid Solution Tab
  - Prilosec
  - Dexilant
  - Aciphex
  - Protonix
  - Zegerid.

This listing is subject to change.
Every year, during annual enrollment, you have the option to select the:

- Preferred Provider Organization (PPO) Dental Plan, administered by Healthplex;
- Dental PPO Plan, administered by DDS, Inc.; or the
- Dental Maintenance Organization (DMO) Dental Plan, insured and administered by Aetna.

and to provide coverage for you and your eligible Dependents. Although these plans provide extensive dental care coverage, the way that each plan delivers care and pays benefits is very different. For example, with the PPO you may visit any provider you would like without needing a referral. With the DMO, your out-of-pocket costs are generally lower than with a PPO, but you must choose a primary care dentist (PCD) and have that dentist coordinate all of your care. The DMO does not provide Out-of-Network benefits. The DDS Plan offers both In-Network and Out-of-Network services.

The following sections describe how the dental options operate. If you have any questions, be sure to call the Fund Office or the insurance provider.

During annual enrollment, make sure you understand how your dental plan options work so that you select the plan that will best suit your and your family’s needs.
The IUOE Local 30 Benefits Trust Fund is designed to help you pay for necessary dental care. Read this section carefully to fully understand which expenses are covered, keeping in mind that the Plan covers only those services that are considered essential to good dental health. A list of covered dental expenses starts on page 48.

How Eligible Dental Expenses Are Defined
To be considered for reimbursement, a dental service must meet the following three criteria:

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

How to Use the Plan
The fee-for-service plan provides for free choice of dentists and pays specific allowances when covered services are rendered. To further enhance the benefit, Healthplex has provided a PPO Network of conveniently located dental offices that will treat Fund members without any out-of-pocket expense for most covered services. There are some differences in the Plan depending upon your provider selection.

In-Network (PPO) Benefits. When you receive covered services from a participating Healthplex provider, the Plan pays 100% of your eligible dental expenses except for Orthodontics. For Orthodontics, there is a $750 copayment per eligible Dependent child under the age of 19. There are no claim forms for you to complete. All benefits are subject to Plan limits as described in the following pages. For a listing of participating PPO dentists in your area, go to www.healthplex.com or call (800) 468-0600.

When you call to make an appointment with a participating Healthplex PPO dentist, please verify that your dentist accepts the IUOE Local 30 fee schedule as payment in full. Otherwise, you will be responsible for paying part of the dentist’s charges.

Out-of-Network Benefits. If you elect to receive services at a non-participating dental office, you will be responsible for all charges above the Out-of-Network reimbursement schedule in addition to any applicable deductible. For example, if the allowed amount for a routine exam is $15 but your dentist charges you $125, you will be responsible for $110. When using an Out-of-Network provider, you must submit a claim form in order to receive benefits. All benefits are subject to Plan limits as described in the following pages.

Maximum Benefits
There is a $50 per person/$150 per family annual Out-of-Network deductible (waived for preventive and diagnostic services). The deductible does not apply if services are rendered by an In-Network participating PPO provider. There is a $2,000 annual maximum for each covered person. The annual maximum does not apply to routine pediatric services provided to Dependent children under age 19.

Pre-treatment Estimate
The Pre-treatment Estimate allows you and your dentist to know which expenses you can expect the Plan to cover and how much will be paid for a particular course of treatment. The Pre-treatment Estimate is an estimate of the amount and scope of benefits payable under the Plan. It is not a guarantee of benefit payments, which are determined when you submit a claim for the actual services and/or supplies rendered during a course of dental treatment.
When to Obtain a Pre-treatment Estimate. If a course of treatment can reasonably be expected to involve covered dental expenses of $250 or more, a description of the procedures to be performed and an estimate of the dentist’s charges must be filed with Healthplex before the course of treatment begins. If a description of the procedures to be performed and an estimate of the dentist’s charges are not submitted in advance, Healthplex reserves the right to make a determination of benefits payable.

How to Receive an Estimate. Have your dentist submit a description of the proposed treatment, an estimate of the charges along with X-rays and other appropriate diagnostic and evaluative materials to Healthplex. If you or your dentist are uncertain about the types of supporting documentation required for your Pre-treatment Estimate, contact Healthplex for a detailed description.

Understanding what’s meant by a “course of dental treatment.” A course of dental treatment is a planned program of one or more services or supplies provided by one or more dentists to treat a dental condition diagnosed by the attending dentist as a result of an oral examination. A course of treatment starts on the date your dentist first provides a service to correct or treat the diagnosed dental condition. If you go to your dentist and an exam is performed, he or she should advise you of all the problems (for example, five cavities and one root canal) with your teeth, not just some of the problems. Whether you choose to have all the work done at once or over a period of time is your decision, keeping in mind that if correcting all the problems will exceed $250, a Pre-treatment Estimate is recommended.

Schedule of In-Network (PPO) Copayments and Out-of-Network Dental Allowances

Here is a representative sample of the PPO Dental Plan’s In-Network benefits and Out-of-Network allowances as of the date this booklet was printed. For the latest schedule, please contact Healthplex or the Fund Office.

<table>
<thead>
<tr>
<th>Provision</th>
<th>In-Network Copayments</th>
<th>Out-of-Network Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>How You Access Care</td>
<td>Go to any Healthplex participating PPO dentist who accepts the IUOE Local 30 fee schedule.</td>
<td>Go to any licensed/certified dentist who does not participate with Healthplex.</td>
</tr>
<tr>
<td>Annual Deductible (waived for diagnostic and preventive services)</td>
<td>None</td>
<td>$50</td>
</tr>
<tr>
<td>■ Individual</td>
<td></td>
<td>$50</td>
</tr>
<tr>
<td>■ Family</td>
<td></td>
<td>$150</td>
</tr>
<tr>
<td>Annual Maximum Benefit (Does not apply to routine pediatric services provided to Dependent children under age 19)</td>
<td>$2,000</td>
<td></td>
</tr>
</tbody>
</table>

Diagnostic and Preventive Services

<table>
<thead>
<tr>
<th>Provision</th>
<th>In-Network Copayments</th>
<th>Out-of-Network Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Exam (twice a year)</td>
<td>No Charge</td>
<td>$15</td>
</tr>
<tr>
<td>Full Mouth X-rays (one series every 36 months)</td>
<td>No Charge</td>
<td>$45</td>
</tr>
<tr>
<td>Panorex X-rays (one series every 36 months)</td>
<td>No Charge</td>
<td>$40</td>
</tr>
<tr>
<td>Cleaning of Teeth Adult/Child (twice a year)</td>
<td>No Charge</td>
<td>$35/$20</td>
</tr>
<tr>
<td>Fluoride Treatment – up to age 19 (once every 12 months)</td>
<td>No Charge</td>
<td>$25</td>
</tr>
<tr>
<td>Specialty Consultation</td>
<td>No Charge</td>
<td>$35</td>
</tr>
<tr>
<td>Emergency Treatment</td>
<td>No Charge</td>
<td>$25</td>
</tr>
<tr>
<td>Provision</td>
<td>In-Network Copayments</td>
<td>Out-of-Network Allowance</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-----------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>Restorative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amalgam—one surface</td>
<td>No Charge</td>
<td>$35</td>
</tr>
<tr>
<td>Amalgam—two surfaces</td>
<td>No Charge</td>
<td>$45</td>
</tr>
<tr>
<td>Amalgam—three surfaces</td>
<td>No Charge</td>
<td>$55</td>
</tr>
<tr>
<td>Composite filling—one surface</td>
<td>No Charge</td>
<td>$40</td>
</tr>
<tr>
<td>Composite filling—two surfaces</td>
<td>No Charge</td>
<td>$55</td>
</tr>
<tr>
<td>Composite filling—three or more surfaces</td>
<td>No Charge</td>
<td>$70</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine extraction</td>
<td>No Charge</td>
<td>$55</td>
</tr>
<tr>
<td>Surgical extraction</td>
<td>No Charge</td>
<td>$85</td>
</tr>
<tr>
<td>Soft tissue extraction</td>
<td>No Charge</td>
<td>$125</td>
</tr>
<tr>
<td>Partial bony extraction</td>
<td>No Charge</td>
<td>$150</td>
</tr>
<tr>
<td>Full bony extraction</td>
<td>No Charge</td>
<td>$195</td>
</tr>
<tr>
<td>Alveolectomy, without extraction, per quad</td>
<td>No Charge</td>
<td>$101</td>
</tr>
<tr>
<td><strong>Root Canal Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Root canal therapy – anterior</td>
<td>No Charge</td>
<td>$250</td>
</tr>
<tr>
<td>Root canal therapy – bicuspid</td>
<td>No Charge</td>
<td>$300</td>
</tr>
<tr>
<td>Root canal therapy – molar</td>
<td>No Charge</td>
<td>$375</td>
</tr>
<tr>
<td><strong>Periodontics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scaling of teeth, per quad</td>
<td>No Charge</td>
<td>$75</td>
</tr>
<tr>
<td>(once every 18 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perio prophylaxis</td>
<td>No Charge</td>
<td>$60</td>
</tr>
<tr>
<td>Gingivectomy, per quad</td>
<td>No Charge</td>
<td>$150</td>
</tr>
<tr>
<td>Osseous surgery, per quad</td>
<td>No Charge</td>
<td>$375</td>
</tr>
<tr>
<td><strong>Prosthetics – Fixed, Removable</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(crowns, bridges and dentures covered once every 60 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acrylic with metal crown</td>
<td>No Charge</td>
<td>$350</td>
</tr>
<tr>
<td>Porcelain crown</td>
<td>No Charge</td>
<td>$350</td>
</tr>
<tr>
<td>Porcelain with metal crown</td>
<td>No Charge</td>
<td>$425</td>
</tr>
<tr>
<td>Stainless steel crown (up to age 16)</td>
<td>No Charge</td>
<td>$90</td>
</tr>
<tr>
<td>Cast post</td>
<td>No Charge</td>
<td>$135</td>
</tr>
<tr>
<td>Acrylic with metal bridge crown or pontic</td>
<td>No Charge</td>
<td>$350</td>
</tr>
<tr>
<td>Porcelain with metal bridge crown or pontic</td>
<td>No Charge</td>
<td>$425</td>
</tr>
</tbody>
</table>
Note: Each month of active or passive orthodontic treatment given before the patient is covered by the Plan reduces the maximum number of months of that treatment that will be covered by the Plan. The Plan will not pay any part of the cost of any orthodontic appliances inserted when the patient was not covered by the Plan.

**Determining When Treatment Begins**

The Plan pays for dental treatment that begins after you or your Dependents become covered. The person must be covered on the date dental treatment is received. While most dental treatment is considered to have been received on the date the work is done, there are some types of treatment that take more than one visit to complete. In these cases, treatment will be considered to have been received on the date shown below:

- Fixed bridgework, crowns, inlays and gold restorations — the date the tooth or teeth are first prepared.
- Full or partial removable dentures — the date the impression is taken.
- Root canal work — the date the pulp chamber of the tooth is opened.
- Orthodontics — the date the first active appliance is installed.

**Benefits When Alternate Procedures Are Available**

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

**Benefits After Coverage Ends**

The following dental services may be covered even if they are completed after your coverage ends.

- Fixed bridgework, crowns, inlays, onlays or gold restorations, if the tooth or teeth fully are first prepared while you are covered by the Plan and the service or supply is furnished within 90 days after coverage ends.
- Full or partial removable dentures, if the impression is taken while you are covered by the Plan and the dentures are installed within 90 days after coverage ends.
- Root canal therapy, if the pulp chamber of the tooth is opened while you are covered by the Plan and the treatment is completed within 90 days after coverage ends.
- Treatment of an accidental injury to natural teeth, if the accident occurs while you are covered by the Plan and the treatment is completed within 90 days after coverage ends.

The benefits described above are not payable if the expenses are payable under any other group plan.

Benefits for orthodontics stop when coverage stops. There are no benefits available for orthodontia charges made after coverage stops or treatment stops for any reason.

<table>
<thead>
<tr>
<th>Provision</th>
<th>In-Network Copayments</th>
<th>Out-of-Network Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full upper or lower denture including adjustments</td>
<td>No Charge</td>
<td>$525</td>
</tr>
<tr>
<td>Partial upper or lower denture, cast base</td>
<td>No Charge</td>
<td>$575</td>
</tr>
<tr>
<td>Broken body of denture</td>
<td>No Charge</td>
<td>$45</td>
</tr>
<tr>
<td>Replacement of broken/missing teeth</td>
<td>No Charge</td>
<td>$45</td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis and treatment of Class II and Class III malocclusions (eligible Dependent children under age 19 only)</td>
<td>$750</td>
<td>$1,000</td>
</tr>
</tbody>
</table>
What is Not Covered by the Healthplex Dental Plan

The Healthplex Dental Plan will not reimburse or make payments for expenses incurred for, caused by, or resulting from:

- Treatment by someone other than a dentist, except for services provided by a licensed dental hygienist under the supervision and guidance of a dentist.
- Treatment of a disease, defect or injury covered by a major medical plan, Workers’ Compensation Law, Occupational Disease Law or similar legislation.
- General anesthesia, analgesia and any service rendered in a hospital environment.
- Dental surgery or treatment performed for the purpose of improving the patient’s appearance (cosmetic dentistry), or dental care to treat accidental injuries or congenital or developmental deformations.
- Restorations, crowns or fixed prosthetics when acceptable results can be achieved with alternative methods or materials.
- Services which were started before the patient’s Plan coverage started.
- Implants, grafts, precision attachments or other personalized restorations or specialized techniques.
- Replacement of any existing crown, bridge or denture which can be made serviceable according to common dental standards.
- Procedures, appliances or restorations (except full dentures) whose main purpose is to change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; lengthen crowns; or restore occlusion.
- Services not listed in the Schedule of Benefits are not covered.

Coordination of Benefits (COB)

Coordination of Benefits is the method in which claims are processed when the patient is covered by more than one insurance company. When this occurs, Healthplex will follow the guidelines developed by the National Association of Insurance Commissioners in order to determine the primary and secondary payors. Under COB rules, both plans may pay up to their maximum amounts as long as the total does not exceed the dentist’s fees being charged.

Each insurance carrier or service provider under this Plan reserves the right to obtain and exchange benefit information from any other insurance carrier, organization or individual to determine the applicability of the Coordination of Benefits provisions. When an overpayment has been made, each insurance carrier or service provider has the right to recover the excess payment from the individual insurance carrier or organization to which payment has been made.

How to Claim Dental Benefits

**In-Network Dental Services.** When you use a Healthplex PPO participating dentist, there are no claim forms to file. Your provider processes claims for you.

**Out-of-Network Dental Services.** If you see an Out-of-Network dentist, you must submit a dental claim form in order to receive benefits. Dental claim forms are available from the Fund Office or at www.Healthplex.com. Send the completed form, a copy of the itemized bill, X-rays, and all other relevant information, including spouse and Dependent children information, to:

Healthplex, Inc.  
333 Earle Ovington Blvd., Suite 300  
Uniondale, NY 11553-3608

To avoid processing delays, make sure the following required information is included with all claims and Pre-treatment Estimates:

- Member’s name, identification number, group name and number.
- Patient’s name and date of birth.
- Provider’s name, address, signature and tax identification number.
- Description of Service(s), CDT codes and charge(s).
- Include appropriate diagnostic materials such as pre- and post-op X-rays, perio charting, models/photos.
- Explanation of Benefits from primary carrier if you are coordinating benefits.
- Indicate assignment of benefits.
The Dental Maintenance Organization (DMO) Dental Plan, administered by Aetna, provides coverage for a wide range of services at little or no out-of-pocket costs for you when you use a participating Primary Care Dentist (PCD). To use the DMO, simply select a PCD and then visit your PCD as needed for treatment and care. Your PCD must provide or coordinate all of your dental services. In return, you enjoy a high level of benefits coverage with low out-of-pocket costs.

Your Primary Care Dentist

You and each Dependent enrolled in the DMO Plan must select a Primary Care Dentist. Each family member can pick his or her own PCD. You choose your PCD from a wide selection of carefully screened Aetna providers. Each time you need dental care you must visit your PCD, who is responsible for coordinating and managing all of your health care needs.

If you need treatment by a specialist, your dentist will arrange a referral to a Participating Specialist Dentist within the Network. DMO members may visit an orthodontist without first obtaining a referral from their primary care dentist.

When you receive care that’s provided or authorized by your PCD, there is no annual deductible to meet before benefits become payable, no annual or lifetime benefit maximums, no annual limit on the number of visits, and no claim forms to submit. However, frequency limitations do apply to certain procedures.

You are responsible for paying 40% coinsurance for certain covered dental services and 50% for covered orthodontia services. The accompanying chart shows current DMO coinsurance requirements for certain services. Contact Aetna if you have questions about coinsurance or covered services.

How to find a Primary Care Dentist.

To find out if your dentist is in the DMO provider Network, visit DocFind, Aetna’s online provider directory (www.aetna.com/docfind) or contact Member Services at (877) 238-6200. Please note that not every provider listed in the directory will be accepting new patients. You should call the dentist’s office and verify this prior to selecting a provider.

Overview of Eligible Aetna DMO Expenses

Here is a representative sample of the DMO Dental Plan’s In-Network benefits.

<table>
<thead>
<tr>
<th>Provision</th>
<th>In-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>How You Access Care</td>
<td>Go to any DMO dentist.</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Office Visit Copay</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Coinsurance:</td>
<td></td>
</tr>
<tr>
<td>■ Preventive Services</td>
<td>None (Plan pays 100%)</td>
</tr>
<tr>
<td>■ Basic Services</td>
<td>None (Plan pays 100%)</td>
</tr>
<tr>
<td>■ Major Services</td>
<td>40% (Plan pays 60%)</td>
</tr>
<tr>
<td>■ Orthodontia</td>
<td>50% (Plan pays 50%)</td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Provision</td>
<td>In-Network Coverage</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Preventive and Diagnostic Services</strong></td>
<td></td>
</tr>
<tr>
<td>Oral Exam (four a year)</td>
<td>100%</td>
</tr>
<tr>
<td>Cleaning (twice a year)</td>
<td>100%</td>
</tr>
<tr>
<td>Fluoride Treatment (once every 12 months under age 18)</td>
<td>100%</td>
</tr>
<tr>
<td>Sealants (permanent molars only) (once every three years)</td>
<td>100%</td>
</tr>
<tr>
<td>Bitewing X-rays (two sets every 12 months)</td>
<td>100%</td>
</tr>
<tr>
<td>Full Mouth Series X-rays (one series every 36 months)</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Basic Services</strong></td>
<td></td>
</tr>
<tr>
<td>Root canal therapy, with X-rays and cultures (anterior teeth/bicuspid teeth)</td>
<td>100%</td>
</tr>
<tr>
<td>Amalgam fillings</td>
<td>100%</td>
</tr>
<tr>
<td>Composite fillings (anterior teeth only)</td>
<td>100%</td>
</tr>
<tr>
<td>Stainless steel crowns</td>
<td>100%</td>
</tr>
<tr>
<td>Scaling and root planing (four separate quadrants per year)</td>
<td>100%</td>
</tr>
<tr>
<td>Gingivectomy (per quadrant)</td>
<td>100%</td>
</tr>
<tr>
<td>Incision and drainage of abscess</td>
<td>100%</td>
</tr>
<tr>
<td>Uncomplicated extractions</td>
<td>100%</td>
</tr>
<tr>
<td>Surgical removal of erupted tooth</td>
<td>100%</td>
</tr>
<tr>
<td>Surgical removal of impacted tooth (soft tissue)</td>
<td>100%</td>
</tr>
<tr>
<td>Denture repairs</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Major Services</strong></td>
<td></td>
</tr>
<tr>
<td>Root canal therapy, molar teeth, (includes necessary local anesthetics)</td>
<td>60%</td>
</tr>
<tr>
<td>Osseous surgery (per quadrant)</td>
<td>60%</td>
</tr>
<tr>
<td>Surgical removal of impacted tooth (partial bony/full bony)</td>
<td>60%</td>
</tr>
<tr>
<td>General anesthesia/intravenous sedation</td>
<td>60%</td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>60%</td>
</tr>
<tr>
<td>Inlays</td>
<td>60%</td>
</tr>
<tr>
<td>Onlays</td>
<td>60%</td>
</tr>
<tr>
<td>Crowns</td>
<td>60%</td>
</tr>
<tr>
<td>Full and partial dentures</td>
<td>60%</td>
</tr>
<tr>
<td>Pontics</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Orthodontia Services</strong></td>
<td></td>
</tr>
<tr>
<td>Comprehensive orthodontic treatment (eligible Dependent children under age 20 only)</td>
<td>50%</td>
</tr>
</tbody>
</table>
Benefits When Alternate Procedures Are Available

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

Out-of-Area Emergency Dental Care

Out-of-area emergency dental care consists of necessary covered dental services given to you by a non-participating dentist to relieve pain or stabilize an emergency condition. Aetna will provide coverage for reasonable charges incurred by you or your Dependents up to $100 regardless of the number of treatments needed for each separate emergency condition when care is provided outside of the 50-mile radius of your home address.

Benefits After Coverage Ends

Dental services given after your coverage terminates are not covered. However, ordered inlays, onlays, crowns, removable bridges, cast or processed restorations, dentures, fixed bridgework, and root canals will be covered when ordered, if the item is installed or delivered no later than 30 days after coverage terminates.

“Ordered” means prior to the date coverage ends:

- For dentures, impressions have been taken from which the denture will be prepared;
- For root canals, the pulp chamber was opened;
- For any other covered item, the teeth that will serve as retainers or support, or that are being restored, have been fully prepared to receive the item and impressions have been taken from which the item will be prepared.

What’s Not Covered by the Aetna DMO Dental Plan

Certain services and supplies are not covered under the Aetna DMO, including, but not limited to, those:

- Covered under any other plan of group benefits provided by or through your employer.
- To diagnose or treat a disease or injury that is not a non-occupational disease or a non-occupational injury.
- Not listed in the Dental Care Schedule.
- For replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
- For plastic, reconstructive or cosmetic surgery, or other dental services or supplies that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons; except to the extent needed to repair an injury. Surgery must be performed in the calendar year of the accident that caused the injury, or in the next calendar year. Facings on molar crowns and pontics are always considered cosmetic.
- For or in connection with experimental treatment still under clinical investigation by health professionals.
- For dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or correcting attrition, abrasion or erosion.
- For an appliance or a modification of an appliance, if an impression for it was taken before the person became covered under the Plan.
- For a crown, bridge or cast or process restoration if a tooth was prepared for it before the person became covered under the Plan.
- For root canal therapy if the pulp chamber for it was opened before the person became covered under the Plan.
- For services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if the services are prescribed, recommended or approved by the attending physician or dentist.
- For services intended for treatment of any jaw joint disorder.
- For space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
- For orthodontia, except as specified.
- For general anesthesia and intravenous sedation, unless done in conjunction with another necessary covered service.
- For treatment by a provider other than a dentist, except for scaling or cleaning of teeth and topical application of fluoride performed by a licensed dental hygienist and provided under the supervision and guidance of a dentist.
- In connection with a service given to a covered Dependent age five or older, if that person becomes covered after 31 days of becoming eligible or after the annual open enrollment period. This does not apply to charges incurred:
  - after the end of the 12 months starting on the date the person’s coverage under the plan began;
as a result of accidental injuries sustained while the person was covered under the Plan; or

for a service listed in the Dental Care Schedule under “Preventive and Diagnostic Services.”

■ For services provided by a nonparticipating provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule.

■ For a crown, cast or processed restoration unless:

  □ it is treatment for decay or traumatic injury and the tooth cannot be restored with a filling material; or

  □ the tooth is an abutment to a covered partial denture or fixed bridge.

■ For pontics, crowns, cast or processed restoration made with high-noble metals.

■ For surgical removal of impacted wisdom teeth only for orthodontic reasons.

■ For services needed solely in connection with non-covered services.

■ For services performed where there is no evidence of pathology, dysfunction or disease, other than covered preventive services.

Coverage for orthodontia services and supplies are not covered for the following:

■ Replacement of broken appliances.

■ Re-treatment of orthodontic cases.

■ Changes in treatment necessitated by an accident.

■ Maxillofacial surgery.

■ Myofunctional therapy.

■ Treatment of cleft palate, micrognathia, macroglossia, primary dentition, transitional dentition.

■ Lingually placed direct bonded appliances and arch wires (i.e., “invisible braces”).

■ Charges for an orthodontic procedure if an active appliance for that orthodontic procedure has been installed before your Dependent became covered for this benefit.

■ Charges for an orthodontic procedure for which an active appliance has been installed within the first two years of your Dependent becoming covered for this benefit if you did not enroll your Dependent within the first 31 days of their initial eligibility for coverage.

Note: All DMO dental benefits are insured and administered by Aetna. The insurer has exclusive authority and discretion to award benefits. Accordingly, you will not receive a benefit unless the insurance company determines that you are eligible. A detailed description of the benefit, including limitations and exclusions, and claims and appeals is contained within the Certificate of Insurance, which will be provided to you upon request. If there are any discrepancies between the information contained in this Summary Plan Description and the Certificate of Insurance, the Certificate of Insurance will govern.
DDS offers dental services to eligible participants and their Dependents in two ways: through the In-Network PPO plan and also through a fee-for-service Out-of-Network plan.

The DDS In-Network PPO Plan. When you receive care from an In-Network PPO dentist, the Plan generally pays 100% of your eligible dental expenses, up to Plan limits. Orthodontia services have different limits that are indicated in the Schedule of Benefits (partial listing) below.

The DDS Out-of-Network Plan. This is a fee-for-service plan that reimburses you for covered dental services, up to Plan limits. Plan allowances are shown in the schedule of benefits (partial listing) below. Please keep in mind that you may go to any dentist of your choice, but you will be responsible for paying the difference between what the Plan allows and what your dentist charges. For example, if the allowed amount for a routine oral exam is $15, but your dentist charges you $125, you’d be responsible for the $110 difference.

In addition, if the cost of treatment is expected to be more than $300, ask your dentist to submit a Pre-determination of Benefits Form to DDS, Inc., 1640 Hempstead Turnpike, East Meadow, NY 11554. This will help ensure that you and your dentist know exactly what the Plan will pay towards your treatment before you start.

Maximum Benefits
The maximum annual benefit is $2,000 for each covered individual in each plan. There are also separate Orthodontia lifetime maximums for Dependent children only under the age of 19 – $1,720 under the In-Network PPO Plan and $1,000 under the Out-of-Network plan. The annual maximums do not apply to routine pediatric services provided to Dependent children under age 19.

Schedule of Benefits (partial listing)
For the complete Schedule of Benefits, go the DDS Web site at www.ddsinc.net. Services not listed in the full Schedule of Benefits are not covered.

<table>
<thead>
<tr>
<th>Provision</th>
<th>DDS In-Network PPO Plan</th>
<th>DDS Out-of-Network Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>How You Access Care</td>
<td>Go to any In-Network PPO dentist who accepts the IUOE Local 30 fee schedule.</td>
<td>Go to any licensed dentist of your choice who does not participate in the DDS PPO Network.</td>
</tr>
<tr>
<td>Annual Deductible (waived for diagnostic and preventive services)</td>
<td>None</td>
<td>$50 – Individual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$150 – Family</td>
</tr>
<tr>
<td>Annual Maximum Benefit (Does not apply to routine pediatric services provided to Dependent children under age 19)</td>
<td>$2,000 per covered individual</td>
<td>$2,000 per covered individual</td>
</tr>
</tbody>
</table>

**Diagnostic and Preventive Services**

<table>
<thead>
<tr>
<th>Provision</th>
<th>In-Network PPO Plan</th>
<th>Out-of-Network Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full mouth X-rays (once every 36 months)</td>
<td>100%</td>
<td>$56</td>
</tr>
<tr>
<td>Single films (periapical or bitewing)</td>
<td>100%</td>
<td>$10</td>
</tr>
<tr>
<td>Provision</td>
<td>DDS In-Network PPO Plan</td>
<td>DDS Out-of-Network Plan</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Bitewing series</td>
<td>100%</td>
<td>$21</td>
</tr>
<tr>
<td>Oral Examination (twice a year)</td>
<td>100%</td>
<td>$22</td>
</tr>
<tr>
<td>Emergency dental treatment</td>
<td>100%</td>
<td>$30</td>
</tr>
<tr>
<td>Cleaning of Teeth (twice a year)</td>
<td>100%</td>
<td>$44</td>
</tr>
<tr>
<td>Panorex X-rays (once every 36 months)</td>
<td>100%</td>
<td>$50</td>
</tr>
<tr>
<td>Diagnostic study models</td>
<td>100%</td>
<td>$37</td>
</tr>
<tr>
<td>Fluoride treatments (once every 12 months)</td>
<td>100%</td>
<td>$31</td>
</tr>
<tr>
<td>Sealants</td>
<td>100%</td>
<td>$30</td>
</tr>
<tr>
<td>Space maintainers</td>
<td>100%</td>
<td>$156</td>
</tr>
<tr>
<td>Nightguards</td>
<td>100%</td>
<td>$85</td>
</tr>
<tr>
<td>Specialist consultation</td>
<td>100%</td>
<td>$50</td>
</tr>
</tbody>
</table>

### Restorative Services

<table>
<thead>
<tr>
<th>Provision</th>
<th>DDS In-Network PPO Plan</th>
<th>DDS Out-of-Network Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Silver Amalgam – one surface</td>
<td>100%</td>
<td>$45</td>
</tr>
<tr>
<td>Silver Amalgam – two surfaces</td>
<td>100%</td>
<td>$60</td>
</tr>
<tr>
<td>Silver Amalgam – three surfaces</td>
<td>100%</td>
<td>$75</td>
</tr>
<tr>
<td>Silver Amalgam – four surfaces</td>
<td>100%</td>
<td>$85</td>
</tr>
<tr>
<td>Composite filling – one surface</td>
<td>100%</td>
<td>$50</td>
</tr>
<tr>
<td>Composite filling – two surfaces</td>
<td>100%</td>
<td>$70</td>
</tr>
<tr>
<td>Composite filling – three surfaces</td>
<td>100%</td>
<td>$88</td>
</tr>
<tr>
<td>Composite filling – four surfaces</td>
<td>100%</td>
<td>$95</td>
</tr>
</tbody>
</table>

### Oral Surgery

<table>
<thead>
<tr>
<th>Provision</th>
<th>DDS In-Network PPO Plan</th>
<th>DDS Out-of-Network Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine extractions, per tooth</td>
<td>100%</td>
<td>$66</td>
</tr>
<tr>
<td>Surgical extraction</td>
<td>100%</td>
<td>$110</td>
</tr>
<tr>
<td>Soft tissue impactions</td>
<td>100%</td>
<td>$155</td>
</tr>
<tr>
<td>Bony impactions</td>
<td>100%</td>
<td>$240</td>
</tr>
<tr>
<td>Alveolecctomy, one quadrant</td>
<td>100%</td>
<td>$125</td>
</tr>
<tr>
<td>Frenectomy</td>
<td>100%</td>
<td>$160</td>
</tr>
<tr>
<td>General Anesthesia (first 30 minutes)</td>
<td>100%</td>
<td>$115</td>
</tr>
<tr>
<td>Tissue biopsy</td>
<td>100%</td>
<td>$90</td>
</tr>
<tr>
<td>Excision of tumors</td>
<td>100%</td>
<td>$125</td>
</tr>
<tr>
<td>Incision and drainage</td>
<td>100%</td>
<td>$65</td>
</tr>
<tr>
<td>Provision</td>
<td>DDS In-Network PPO Plan</td>
<td>DDS Out-of-Network Plan</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td><strong>Root Canal Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulp capping, direct</td>
<td>100%</td>
<td>$25</td>
</tr>
<tr>
<td>Pulpotomy</td>
<td>100%</td>
<td>$65</td>
</tr>
<tr>
<td>Root therapy – anterior</td>
<td>100%</td>
<td>$350</td>
</tr>
<tr>
<td>Root therapy – bicuspid</td>
<td>100%</td>
<td>$425</td>
</tr>
<tr>
<td>Root therapy – molars</td>
<td>100%</td>
<td>$500</td>
</tr>
<tr>
<td>Apicoectomy – anterior</td>
<td>100%</td>
<td>$210</td>
</tr>
<tr>
<td>Root amputation</td>
<td>100%</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Periodontics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perio scaling per quad – once</td>
<td>100%</td>
<td>$90</td>
</tr>
<tr>
<td>every 18 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soft tissue graft</td>
<td>100%</td>
<td>$150</td>
</tr>
<tr>
<td>Gingivectomy per quad</td>
<td>100%</td>
<td>$180</td>
</tr>
<tr>
<td>Osseous surgery per quad – once</td>
<td>100%</td>
<td>$460</td>
</tr>
<tr>
<td>every 36 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prosthetics – Crowns</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(crowns, bridges and dentures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>covered once every 60 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acrylic with metal crown</td>
<td>100%</td>
<td>$350</td>
</tr>
<tr>
<td>Porcelain, hi-noble metal crown</td>
<td>100%</td>
<td>$595</td>
</tr>
<tr>
<td>Stainless steel crown</td>
<td>100%</td>
<td>$110</td>
</tr>
<tr>
<td>Cast post</td>
<td>100%</td>
<td>$165</td>
</tr>
<tr>
<td>Recementation, per crown</td>
<td>100%</td>
<td>$38</td>
</tr>
<tr>
<td><strong>Prosthetics – Fixed Bridges</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Porcelain with hi-noble metal</td>
<td>100%</td>
<td>$595</td>
</tr>
<tr>
<td>crown or pontic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Porcelain with base metal crown</td>
<td>100%</td>
<td>$425</td>
</tr>
<tr>
<td>or pontic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recementation, bridge</td>
<td>100%</td>
<td>$62</td>
</tr>
<tr>
<td><strong>Prosthetics – Removable</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full upper or lower denture,</td>
<td>100%</td>
<td>$650</td>
</tr>
<tr>
<td>with adjustments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial upper or lower denture,</td>
<td>100%</td>
<td>$695</td>
</tr>
<tr>
<td>cast chrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denture adjustments</td>
<td>100%</td>
<td>$30</td>
</tr>
<tr>
<td>Broken body of denture</td>
<td>100%</td>
<td>$65</td>
</tr>
<tr>
<td>Replacement of broken/missing</td>
<td>100%</td>
<td>$55</td>
</tr>
<tr>
<td>teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reline dentures</td>
<td>100%</td>
<td>$200</td>
</tr>
</tbody>
</table>
If you want a list of participating dentists in the DDS In-Network PPO Plan or the complete Schedule of Benefits for all covered services, go to www.ddsinc.net, click on “Patients Only” and enter 30 in the “Group #” section. If you want to print a claim form, all you need to do is click on “Providers Only” and then “Submit Claims.”

You can also call (800) 255-5681 and identify yourself as a member of the IUOE Local 30 Benefits Fund to find the dentist nearest you. Make sure you sign and have your union ID card with you when you go to your appointment.

<table>
<thead>
<tr>
<th>Provision</th>
<th>DDS In-Network PPO Plan</th>
<th>DDS Out-of-Network Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orthodontia</strong></td>
<td><strong>Orthodontic consultation</strong> $20</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Orthodontia</strong></td>
<td><strong>Appliance insertion</strong> $250</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Orthodontia</strong></td>
<td><strong>Active monthly treatment</strong> $20 per month (for 24 months, standard cases only)</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Orthodontia</strong></td>
<td><strong>Fixed appliance (pre-orthodontic treatment)</strong> $357.50</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Orthodontia</strong></td>
<td><strong>Lifetime Maximum</strong> $1,720</td>
<td>$1,000</td>
</tr>
</tbody>
</table>
Optical benefits depend on whether you go to your own provider or use a participating vision care center.

- If you use your own provider, the Fund will reimburse you up to $100 for glasses/contacts and up to $25 for eye exams every 12 months.

- If you use a Davis Vision, General Vision Services (GVS) or Vision Screening provider, you can get an annual eye exam at no cost. Glasses and other corrective lenses are available at no cost or at a significant discount, depending on your selection.

A listing of providers will be furnished to you, free of charge, upon request to the Fund Office. Since providers join and drop out of the network, the best place to go for the most up-to-date information is the provider’s website or call Davis Vision, GVS, or Vision Screening. Contact information is shown below.

**Eligible Vision Care Expenses**

The Plan covers the following eligible vision care expenses:

- Eye examinations performed by a legally qualified and licensed ophthalmologist or optometrist

- Prescribed corrective lenses you receive from a legally qualified and licensed optician, ophthalmologist or optometrist.

Frequency and/or dollar limits may apply to some services and supplies. Refer to materials provided by Davis Vision, GVS and Vision Screening for details.

**Laser Eye Surgery**

In addition to the optical benefits described above, the Fund will pay 80% of your eligible expenses for laser vision surgery, up to a lifetime maximum benefit of $1,000 per eye. The laser eye surgery benefit is administered by the Fund Office, as well as by MagnaCare. Contact the Fund Office for more information.

**In-Network Benefits**

For Vision Screening, all you need to do is visit a participating Vision Screening location to receive benefits.

To use an In-Network provider:

- Call the In-Network provider of your choice to schedule an appointment;

- Identify yourself as an IUOE Local 30 member or dependent;

- Provide the office with the member ID number and the name and date of birth of any covered dependents needing services.

All of the participating Networks have various locations, so be sure to ask for the location nearest you.

<table>
<thead>
<tr>
<th>Network Provider</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Davis Vision</td>
<td>(800) 999-5431</td>
<td><a href="http://www.davisvision.com">www.davisvision.com</a></td>
</tr>
<tr>
<td>GVS</td>
<td>(800) 847-4661</td>
<td><a href="http://www.generalvision.com">www.generalvision.com</a></td>
</tr>
<tr>
<td>Vision Screening</td>
<td>(800) 652-0063</td>
<td><a href="http://www.VScreening.com">www.VScreening.com</a></td>
</tr>
</tbody>
</table>
Out-of-Network Benefits

If you go to a provider who is not part of a Network, you pay the full cost of the services and items you purchase. You must then submit your vision claim form, along with a copy of the itemized bill, to the Fund Office for reimbursement, up to Plan limits. The Fund will cover up to $100 for eyeglasses or contact lenses and $25 for the eye exam every 12 months.

Ineligible Vision Care Expenses

The Plan’s vision care coverage will not make payments for, or reimburse any part of, expenses incurred for, caused by, or resulting from:

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

Hearing Aid Benefit

GVS, one of our optical benefits providers, also offers a hearing aid benefit for Plan participants through its subsidiary, General Hearing Services. You may obtain a comprehensive hearing evaluation and a standard hearing aid for each ear at a GVS center. You’ll also receive a three-year warranty for repairs, one-time loss or damage warranty, and one-year supply of batteries for each hearing aid.

The maximum benefit is $500 per ear once every three years with a $100 copay required for a standard hearing aid. You may apply your benefit toward any upgraded programmable digital hearing aid with advance circuitry and receive a 20% to 50% discount.

To find the GVS location nearest you that can provide you with these benefits, call 1-888-899-1447 (you can reference account number 6156H). You do not need to use GVS optical benefits to access your hearing benefits.
Short-term disability (STD) benefits provide a source of income if you become unable to work due to a non-work-related injury or illness. The STD benefit, which is administered by The Union Labor Life Insurance Company (“Union Labor Life”) and provided under the New York State Disability Insurance (SDI) law, replaces 50% of your pay (as defined by state law), up to a $170 maximum weekly benefit, for up to 26 weeks of disability. STD benefits are not payable for injuries or illnesses arising out of or in the course of your employment.

To receive disability benefits, you must be under the care of a physician and he or she must certify to the Fund that you are disabled. Weekly benefits for pregnancy will be provided in the same manner as benefits for an “illness.”

When Benefits Begin
If you are absent because of an accidental injury, benefits start on your first day of absence. If you are absent because of sickness, illness or pregnancy, benefits are payable from your eighth day of absence (although payments will be retroactive to your first day of disability).

Duration of Benefit Payments
Whether your disability is due to illness or injury, benefits are payable for up to 26 weeks for each period of disability in any 52-week period. The 26-week maximum applies to any one period of disability, whether from one or more causes, or for successive periods of disability due to the same or related cause or causes. A successive period of disability will be considered a new period of disability if you return to work between periods of disability resulting from different and unrelated causes, or you return to work for six consecutive months between periods of disability resulting from the same or related causes.

Disabilities Not Covered by the Plan
No benefits are payable for:

- Any period during which you are not under a physician’s care.
- Any period during which you are receiving benefits under Workers’ Compensation or any similar state or federal law.

Claiming Short-Term Disability Benefits
You must notify the Fund Office in writing of your disability resulting from a non-work related injury or illness. The Fund Office will send you the appropriate claim form necessary to receive short-term disability benefits.

Note: All Short-Term Disability benefits under the Plan are provided under New York State Disability Insurance law and administered by The Union Labor Life Insurance Company and there are no benefits payable from any other source. The insurer has exclusive authority and discretion to award benefits. Accordingly, you will not receive a benefit unless the insurance company determines that you are eligible. A detailed description of the benefit, including limitations and exclusions, and claims and appeals is contained within the Certificate of Insurance, which will be provided to you upon request. If there are any discrepancies between the information contained in this Summary Plan Description and the Certificate of Insurance, the Certificate of Insurance will govern.
You are eligible for life insurance the first day of the calendar month following completion of eight (8) consecutive weeks of active employment. Your life insurance coverage is fully insured by The Union Labor Life Insurance Company (“Union Labor Life”). Life insurance benefits in the amount of $50,000 are payable to your beneficiary if you die while coverage is in effect.

About Your Beneficiary

Your beneficiary will be the person or persons you designate in writing on a form that’s kept on file at Union Labor Life. Your beneficiary can be anyone you choose, and you can change your beneficiary designation at any time by completing and submitting a revised Enrollment Form to the Fund Office. If, however, there is a divorce decree or another court order that directs you to name a particular person as a beneficiary, you may not be able to change your beneficiary designation.

Your Life Insurance beneficiary is the same as your AD&D Insurance beneficiary unless you choose otherwise. Contact the Fund Office if you want to name a different beneficiary for AD&D Insurance.

If you do not name a beneficiary, or if your beneficiary dies before you and you have not named a new beneficiary, your life insurance benefit will be payable in the following order:

- Your wife or husband, if living
- Your living children, equally
- Your living parents, equally
- Your living brothers and sisters, equally
- If none of the above, to your estate.

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

If You Become Disabled — Waiver of Premium

You may apply to continue your life insurance under the Waiver of Premium provision if you are under the age of 60 and:

- You become Totally Disabled while insured under this policy;
- You have been Totally Disabled for at least nine (9) months; and

Premium payments continue to be made or your coverage is terminated for failure to meet the eligibility requirements stated in the policy due to Total Disability.

Note that the initial continuation of insurance under this provision will be for 12 months from the date premium payments on your behalf end, but in no event will be longer than 24 months from the date Total Disability started. Waiver of Premium will continue until the earlier of:

- The date your Total Disability ends; or
- The end of the 12-month period.

“Totally Disabled” and “Total Disability” mean your complete inability, due to injury or illness, to engage in any business, occupation or employment for which you are qualified or become qualified by education, training or experience, for pay, profit or compensation.

You must submit satisfactory written proof (“Initial Proof”) of Total Disability within 12 months from the date premium payments on your behalf end, but in no event more than 24 months from the date Total Disability began.

When Coverage Ends

Life insurance coverage ends on the last day of the month following the month in which you cease full-time employment with a participating employer.
Conversion Privileges

If your life insurance benefit ends, you may convert all or a portion of the amount of insurance that has been terminated. The amount converted to an individual policy cannot be more than the $50,000 of group coverage you had under the policy. To qualify for a conversion policy, you must submit a written application to Union Labor Life and pay the first premium due within 31 days from the date your life insurance benefit ends. Your coverage will continue for as long as you make the required premium payments. You may convert to any individual policy that is being offered by Union Labor Life; however, at your option, your conversion policy may be preceded by preliminary term life insurance for not more than one year. Evidence of good health is not required to convert your coverage to an individual policy.

Claiming Life Insurance Benefits

Your beneficiary must notify the Fund Office in writing of your death (i.e., certified copy of your death certification). Your beneficiary will be provided with the appropriate claim form necessary to receive benefits.

Note: All Life Insurance benefits under the Plan are provided by insurance and there are no benefits payable from any other source. The insurer has exclusive authority and discretion to award benefits. Accordingly, you will not receive a benefit unless the insurance company determines that you are eligible. A detailed description of the benefit, including limitations and exclusions, and claims and appeals is contained within the Certificate of Insurance, which will be provided to you upon request. If there are any discrepancies between the information contained in this Summary Plan Description and the Certificate of Insurance, the Certificate of Insurance will govern.
YOUR ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE BENEFITS

Accidental Death & Dismemberment (AD&D) Insurance, which is fully insured by The Union Labor Life Insurance Company (“Union Labor Life”), is in effect 24 hours a day. It is worldwide protection that applies to accidents on or off the job, at home or away from home. You are eligible for life insurance the first day of the calendar month following completion of eight (8) consecutive weeks of active employment.

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

Only one amount – the largest to which the insured is entitled – will be paid for all losses resulting from a single accident. The loss must take place within 90 days after an accident for AD&D benefits to be payable. Any claim payable under the Plan must be filed within 90 days after a loss is incurred.

Contact the Fund Office to claim AD&D benefits.

How AD&D Benefits Work

Your AD&D Insurance coverage is shown in the following chart. Benefits are payable to your beneficiary if you die, or to you if you are severely injured in an accident (except those specifically excluded on page 66). AD&D Insurance benefits are payable in addition to any other coverage you may have. Your beneficiary can be the same as your life insurance beneficiary on file with Union Labor Life unless you choose otherwise.

<table>
<thead>
<tr>
<th>Loss</th>
<th>Benefit Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>$50,000</td>
</tr>
<tr>
<td>Both hands at or above the wrist; both feet at or above the ankle; eyesight in both eyes; or any combination of hand, foot and eyesight</td>
<td>$50,000</td>
</tr>
<tr>
<td>One hand at or above the wrist; one foot at or above the ankle; or eyesight in one eye</td>
<td>$25,000</td>
</tr>
</tbody>
</table>
What’s Not Covered

No AD&D Insurance benefits will be paid for any loss that is caused directly or indirectly, or in whole or in part, by any of the following:

- Bodily or mental illness or disease of any kind;
- Ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
- Medical or surgical treatment of an illness or disease;
- Suicide or attempted suicide;
- Intentional self-inflicted injury;
- Participation in a felony or a riot;
- War or act of war, declared or undeclared; or any act related to war or insurrection;
- Service in the Armed Forces or units auxiliary to the Armed Forces; or
- Police duty as a member of any military, naval or air organization.

When Coverage Ends

AD&D insurance coverage ends when your life insurance coverage ends.

Claiming AD&D Insurance Benefits

You or your beneficiary must notify the Fund Office in writing of your accidental loss or your death within 90 days after the date of the loss. You or your beneficiary will be provided with the appropriate claim form necessary to receive benefits.

Note: All Accidental Death & Dismemberment (AD&D) Insurance benefits under the Plan are provided by insurance and there are no benefits payable from any other source. The insurer has exclusive authority and discretion to award benefits. Accordingly, you will not receive a benefit unless the insurance company determines that you are eligible. A detailed description of the benefit, including limitations and exclusions, and claims and appeals is contained within the Certificate of Insurance, which will be provided to you upon request. If there are any discrepancies between the information contained in this Summary Plan Description and the Certificate of Insurance, the Certificate of Insurance will govern.
GROUP LEGAL SERVICES FUND

Eligibility

Who is eligible? All active full-time employees, and their lawful spouse, who are members of a collective bargaining unit covered by a Collective Bargaining Agreement with IUOE Local 30 and a Contributing Employer, which provides for a Legal Services Benefit.

When do you become eligible? You are eligible for benefit coverage on the first day of the calendar month following completion of 30 days of consecutive active employment with a Contributing Employer.

How the Plan Works

The Fund offers a variety of legal services, including both phone consultations and legal representation. Each time you need legal services, contact the Fund Office for instructions on how to make an appointment with an attorney.

Confidentiality. All services provided to you by the Legal Provider’s staff will be kept in strictest confidence. Communications with the attorney and the law firm are within the attorney-client privilege.

When you contact the Fund Office regarding eligibility for legal benefits, you should only discuss with the Fund staff general information regarding the nature of your matter. Neither the Benefits Trust Fund nor the Union will have access to files or any information regarding services provided to you by the Legal Provider.

Closed Panel Law Firm System. When you retain a Legal Provider through the Plan, an attorney-client relationship will be exclusively established between you and the Law Firm. The Plan has been established as a continuing operation to provide high caliber legal service at a reasonable cost. Therefore, no reimbursement whatsoever can be provided to you or any other attorney. However, if you live in Connecticut or New Jersey, the Plan will reimburse you for up to $400 in covered expenses incurred with a law firm outside of the Plan’s closed panel.

Legal services are provided on a strictly confidential basis. Neither your employer, the Local 30 Benefits Trust Fund nor the Union will have access to your legal information.

Amount of Legal Service You Receive

You or your spouse may receive up to 10 hours of legal services in any consecutive 12 months. It is not anticipated that matters will require more than 10 hours. However, if your matter exceeds your available hours of service, at your discretion the Legal Provider will continue representing you, but you are responsible for legal fees that exceed the Plan’s maximum benefit. If the Legal Provider anticipates that your matter will exceed the Plan’s maximum benefit, the Legal Provider will discuss with you the fees and rates that will be charged for these services. You must agree in writing to retain the Legal Provider for the excess services before these services are performed.

Your costs. You will be charged all costs and expenses paid by the Legal Provider on your behalf in representing your matter. In the event such costs are substantial, you may be required to prepay these costs and expenses. These costs and expenses typically are witness fees, title and lien searches, stenographic costs, filing fees, fines, attorney’s travel costs, or extraordinary mail and reproduction costs.
What's Covered

The Plan’s Legal Provider can help you with such matters as:

■ General Consultation;
■ Advice, but not representation, in criminal matters;
■ Legal advice and research;
■ Drafting of simple wills and trust agreements;
■ Probates of simple wills and administration of simple estates where the Eligible Member is Executor and no litigation is involved;
■ Purchase and/or sale of personal residence (including house closings);
■ Retail credit and other consumer contracts;
■ Credit Counseling.

What's Not Covered

All legal services and matters not specifically listed as a covered service or matter are not included within the Plan and you will not be entitled to any service not included. If you have any questions as to whether your legal problem is covered by the Plan, call the Fund Office (718) 847-8484, extension 208. Some examples of matter excluded from the Plan are:

■ Employer disputes, controversies, proceedings, grievance or suits including Workmen's Compensation and Unemployment Insurance Claim cases;
■ Any dispute, grievance, proceeding, controversy or suit that involves or is against the Union or any of its related benefit trust funds;
■ Any controversy or proceeding in which a labor organization would be prohibited by law from defraying costs of legal services;
■ Controversies, disputes or proceeding between Eligible Members or an Eligible Member and the family of another Eligible Member.

■ Legal services generally handled on a contingency fee basis; Legal Services and the cost thereof otherwise paid for by insurance or covered through any government agency or attorney;
■ Defense of civil litigation involving personal injury and damage claims;
■ Class actions or amicus curiae activities; business ventures or pursuits;
■ Preparation of tax returns;
■ Matters of service available to Eligible Member under other group service programs or otherwise available to the Eligible Member without charge;
■ Proceedings where issue has been joined prior to the date this plan becomes operative;
■ Traffic violations;
■ Slander and libel.

The covered legal services can be provided only in Connecticut, New Jersey, and the following counties in the state of New York: the five New York City counties, Westchester, Rockland, Nassau, Suffolk, Putnam, Orange, Sullivan, Ulster, and Duchess Counties.
A claim, to be honored, must be submitted to the appropriate organization in the prescribed format. You are encouraged to submit your claims as soon as possible to avoid missing the claims deadline, which is one year after the expense was incurred.

The Board of Trustees will have the right and opportunity to examine any claimant (while living) when and as often as may reasonable be required, and to make an autopsy where it is not forbidden by law.

Definition of a Claim
A claim for benefits is a request for Plan benefits made in accordance with the Plan’s reasonable claims procedures including filing a claim (where necessary). The claims procedures vary depending on the specific benefit you are requesting. When the procedures require that you file a claim for benefits offered under this Plan, you must submit a completed claim form.

The following are not considered to be claims for benefits:

- Simple inquiries about the Plan’s provisions that are unrelated to any specific benefit claim or are exclusively about eligibility.
- A request for prior approval of a benefit that does not require prior approval by the Plan.
- The presentation of a prescription to a pharmacy that exercises no discretion on behalf of the Plan.
- The presentation of your identification card to a participating provider that exercises no discretion on behalf of the Plan.

The claims procedures vary depending on the Plan of benefits you selected (i.e., depending on whether you are enrolled in an EPO or receive benefits through the PPO). For circumstances where you must file a claim, they must be filed with the appropriate organization listed on the next page. You may obtain a claim form from the Fund Office or the applicable organization.
# How to File Claims

This chart outlines when claims must be filed and to whom they go. Your claim will be considered to have been filed as soon as it is received at the applicable address below by the organization that is responsible for determining the initial determination of the claim.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>How to File Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital: PPO</td>
<td></td>
</tr>
<tr>
<td><strong>In-Network</strong></td>
<td>When you receive care from providers or facilities in the Empire or BlueCard PPO Networks, participating providers are paid directly and you generally do not have to file a claim.</td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td>You will have to file a claim for reimbursement for covered services received Out-of-Network, from a non-participating provider, or if you have a medical emergency out of the Empire service area. To obtain a claim form, call customer service. Send completed forms to:</td>
</tr>
<tr>
<td><strong>Empire BlueCross BlueShield</strong></td>
<td>P.O. Box 1407 Church Street Station New York, NY 10008-1407  <strong>Attention:</strong> Institutional Claims Department</td>
</tr>
<tr>
<td><strong>Note:</strong> You may have to pay a hospital’s bill at some out-of-area and non-participating hospitals. If this happens, be sure you include an original itemized hospital bill with your claim.</td>
<td></td>
</tr>
<tr>
<td>All claims should be filed within 18 months of the date of service.</td>
<td></td>
</tr>
<tr>
<td>Medical: PPO</td>
<td></td>
</tr>
<tr>
<td><strong>In-Network</strong></td>
<td>There are no claim forms for most In-Network services. When you visit a Network provider, you pay the cost-sharing amount, if any, directly to the provider.</td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td>If you go Out-of-Network for medical services, you will need to submit claim forms to:</td>
</tr>
<tr>
<td><strong>MagnaCare</strong></td>
<td>1200 Stewart Avenue Westbury, NY 11590</td>
</tr>
<tr>
<td>Medical: EPO</td>
<td><strong>No claim forms required.</strong> When you visit a participating CIGNA Open Access Plus provider, you pay the cost-sharing amount, if any, directly to the provider. However, if you do need to file a claim, you can do so by contacting CIGNA at the address and phone number listed on your ID card and/or in your CIGNA handbook. This handbook will describe the claims filing deadlines and procedures.</td>
</tr>
<tr>
<td>Prescription Drug</td>
<td><strong>No claim forms required.</strong> When you visit a participating CVS Caremark pharmacy, you pay the cost-sharing amount directly to the pharmacist. For mail orders, obtain a Mail Service Order Form from the Fund Office and mail prescription(s) in the enclosed self-addressed stamped envelope. However, if your request for a prescription is denied in whole or in part, you may file an appeal with the Fund Office.</td>
</tr>
<tr>
<td>Dental: PPO</td>
<td></td>
</tr>
<tr>
<td><strong>In-Network</strong></td>
<td>There are no claim forms for most In-Network services. When you visit an In-Network provider, you pay the cost-sharing amount, if any, directly to the provider.</td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td>If you go Out-of-Network for medical services, you will need to submit claim forms to:</td>
</tr>
<tr>
<td><strong>Healthplex</strong></td>
<td>60 Charles Lindbergh Blvd. Uniondale, NY 11553</td>
</tr>
<tr>
<td>It’s recommended that you submit your claim within 30 days of your date of service. All claims must be submitted within 12 months of the date of service.</td>
<td></td>
</tr>
<tr>
<td>Dental: DMO</td>
<td><strong>No claim forms required.</strong> When you visit a participating Aetna provider, you pay the cost-sharing amount, if any, directly to the provider.</td>
</tr>
</tbody>
</table>
**Benefit** | **How to File Claims**
---|---
Dental: DDS, Inc. | For Out-of-Network claims only: Go to the DDS, Inc. Website at www.ddsinc.net to print claim forms. Click on “Providers Only” and then “Submit Claims.” If you use the Out-of-Network Plan and your treatment will exceed $300, have your dentist submit a Pre-determination of Benefits Form and X-rays to DDS, Inc., 1640 Hempstead Turnpike, East Meadow, NY 11554.
Vision (for Out-of-Network claims only; In-Network claims are handled by the provider) | Submit claim forms to the Fund Office: International Union of Operating Engineers Local 30 Benefits Trust Fund and Group Legal Services Trust Fund 115-06 Myrtle Avenue Richmond Hill, NY 11418 (718) 847-8484
Life Insurance | It’s recommended that you or your beneficiary submit your claim within 30 days of your date of service, death or disability.
Accidental Death & Dismemberment Insurance | Submit claim forms to ULLICO
Short-term Disability | Your claim will be considered to have been filed as soon as it is received by the claims administrator/insurer (organization making the claims decision).

A claim for benefits is a request for Plan benefits made in accordance with the Plan’s reasonable claims procedures. In order to file a claim for benefits offered under this Plan, you may be required to submit a completed claim form. Simple inquiries about the Plan’s provisions that are unrelated to any specific benefit claim will not be treated as claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

When a claim form is required. In order to claim certain benefits offered under the Plan, you must submit a completed claim form. You can get a claim form by contacting the Fund Office at (718) 847-8484 or by visiting the Fund Office during regular office hours (8:30 a.m. to 4:30 p.m., Monday through Friday). The following information must be completed in order for your request for benefits to be a claim, and for the Fund Office to be able to decide your claim.

1. Obtain a claim form from the Fund Office and complete the employee’s portion of the claim form (including your name and Social Security number, the patient name and the patient’s date of birth);
2. Have your physician either complete the Attending Physician’s Statement section of the claim form (including Date of Service, CPT-4 code and ICD-9 diagnosis code), billed charge, number of units (for anesthesia and certain other claims), federal taxpayer identification number of the provider, billing name and address and if treatment is due to accident, accident details);
3. Submit a completed CMS health insurance claim form or UB92 form (for institutional claims) or ADA Dental Claim (for dental claims), or have the provider submit an HIPAA-compliant electronic claims submission and
4. Attach any other itemized hospital bills or doctor’s statements that describe the services rendered.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

Mail any further bills or statements for services covered by the Plan to the applicable organization as soon as you receive them.

Claims involving Urgent Care for MagnaCare claims (defined below) must be submitted telephonically to MedReview by calling (800) 688-2284 if followed in writing within 24 hours with the information listed above. Claims involving Urgent Care for Empire or Cigna, if applicable, must be submitted to Empire or Cigna directly.
When To File Claims

It’s recommended that you file claims within 30 days following the date the charges were incurred. Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and **in no event later than one year** from the date the charges were incurred.

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. You can get a form from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim (defined below) without you having to complete the special authorization form.

Making Claims Determinations

The time frames for deciding whether Health and Welfare Fund claims are accepted or denied will vary depending on whether your claim is for a **Pre-Service Claim**, an **Urgent Care Claim**, a **Concurrent Care Claim**, a **Post-Service Claim**, or a **Disability Claim**. Read each section carefully to determine which procedure is applicable to your request for benefits. Also refer to your insurance certificates for insured benefits.

**Pre-Service Claims.** A Pre-Service Claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Under this Plan, prior approval of services is known as “pre-certification” and is required for the services and supplies listed on page 16.

For properly filed Pre-Service Claims, you and/or your doctor or dentist will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Plan. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If you improperly file a Pre-Service Claim with one of the Fund’s claims administrators, the Fund Office will notify you as soon as possible – but not later than five days after they receive the claim – of the proper procedures to be followed in filing a claim. You will receive notice of an improperly filed Pre-Service Claim only if the claim includes your name, your specific medical condition or symptom and a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision on a Pre-Service Claim and notify you of the determination.

**Urgent Care Claims.** An Urgent Care Claim is any claim for medical care or treatment with respect to which the Plan determines is an Urgent Care Claim. If an Urgent Care Claim is determined by the Fund, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim.

If you improperly file an Urgent Care Claim with one of the Fund’s claims administrators, the Fund Office will notify you as soon as possible – but not later than 24 hours after they receive the claim – of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

If you are requesting pre-certification of an Urgent Care Claim, different deadlines apply. The Plan will respond to you with a determination over the phone as soon as possible taking into account the medical situation, but not later than 72 hours after the Plan receives the claim. The determination will also be confirmed in writing.

If an extension is needed because the Plan needs additional information to determine whether or to what extent benefits are covered or payable, the Fund Office will notify you as soon as possible – but not later than 24 hours after they receive the claim – of the specific information needed. You and/or your doctor must provide the specified information within 48 hours. If the information is not provided within that time, your claim will be denied. The Plan then has 48 hours to make a decision on an Urgent Care Claim and notify you of the determination. Notice of the decision will be provided no later than 24 hours after the Plan receives the specified information.
if the delay for additional information extends beyond 72 hours from the receipt of the claim.

**Concurrent Claims.** A Concurrent Claim is a claim for care that involves an ongoing course of treatment to be provided over a period of time or through a number of treatments, and as a consequence the care is reviewed during the course of treatment to determine whether benefits should be continued, reduced or ended. (An example of this type of claim would be an inpatient hospital stay, originally certified for five days, that is reviewed after three days to determine if the full five days is appropriate.) In this situation a decision to continue, reduce or end treatment is made concurrently with the provision of treatment.

If a benefit administrator decides to reduce or stop paying benefits for a previously-approved course of treatment, they will notify you as soon as possible and give you enough time to appeal the decision before the benefit is reduced or ended. If you wish to extend the course of treatment and the treatment involves Urgent Care (as defined above), the Fund Office will notify you within 24 hours after they receive your claim, as long as you make your claim at least 24 hours before the approved course of treatment is scheduled to end. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

**Post-Service Claims.** A Post-Service Claim is a claim submitted for payment after health services and treatment have been obtained.

If you improperly file a Post-Service Claim, the Fund Office will notify you as soon as possible and give you the opportunity to properly refile the claim. Keep in mind that if a claim form has to be returned to you for information, delays in payment will result.

You do not have to submit an additional claim form if your bills are for a continuing disability and you have filed a claim within the past calendar year. Mail any further bills or statements for any medical or hospital services covered by the Plan to the Fund Office as soon as you receive them.

For properly filed Post-Service Claims, you will be notified of a decision within 30 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Plan. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision on a Post-Service Claim and notify you of the determination.

**Short-Term Disability Claims.** A Disability Claim is any claim that requires a finding of total disability as a condition of eligibility. Disability Claims should be submitted to ULLICO within 30 days after the date of disability. The “date of disability” is the first (1st) day of disability due to a non-work related injury, and the eighth (8th) day from the date you first lose time from work and are treated by a Physician because of disability due to an illness. For short-term disability benefit claims, the Plan reserves the right to have a physician examine you at the Plan’s expense as often as is reasonable to determine your disability status. You will be notified of the determination of your short-term disability benefits in accordance the applicable state law.

**Claims Denial Notification**

A claim denial is also known as an adverse benefit determination. For the purposes of the initial and appeal claims procedures, a claim denial or adverse benefit determination for health care claims is defined as:

- A denial, reduction, or termination of, or failure to provide or make payment in whole or in part for a benefit, including a determination of an individual’s eligibility to participate in this plan, or a determination that a benefit is not a covered benefit; and

- A reduction in a benefit resulting from the application of any utilization review decision, preexisting condition exclusion, source-of-injury exclusion, Network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or
A rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

The Plan will notify you in writing if your claim has been denied, either in full or in part. This notice will state:

- Information sufficient to identify the claim involved, including date of service; provider; claim amount; and a statement that you may request, free of charge, any diagnosis, treatment, and denial codes and their respective meanings;

- The specific reason(s) for the denial;

- Reference to the specific Plan provision(s) on which the denial is based;

- A description of any additional material or information necessary to support the claim, and an explanation of why the material or information is necessary;

- A description of the Plan’s internal appeal procedures (including voluntary appeals, if any), external review procedures and applicable time limits and information regarding how to initiate your appeal;

- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and

- A disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

For Pre-Service, Urgent or Concurrent Care Claims, you will receive notice of the determination even when the claim is approved.

Appealing a Denied Claim (Non-Hospital Claims)

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review.

- **CIGNA Open Access Plus EPO benefits.** For CIGNA Open Access Plus EPO benefits, CIGNA is responsible for hearing appeals. Follow the procedures on the back of your ID card or in your CIGNA member handbook for the address.

- **MagnaCare PPO Medical benefits.** PPO appeals procedures depend on the type of appeal.

- **Pre-Service, Urgent and Concurrent Care Appeals:** Send all requests for Pre-Service, Urgent and Concurrent Care appeals to MedReview at:

  MedReview
  1 Seaport Plaza
  199 Water Street
  New York, NY 10038

  Appeals involving Urgent Care Claims may be made orally by calling MedReview at (800) 688-2284.

MedReview maintains a two-level appeals process for pre-service appeals. Second level pre-service appeals should be submitted to MedReview. Please note that there are no second level appeals available for Urgent and Concurrent claims.

**Post-Service appeals of hospital claims:**

Empire BlueCross BlueShield maintains a two-level appeal for hospital benefits. All first and second level hospital benefit appeals are determined by Empire BlueCross BlueShield. See page 76 for more details on Empire’s complaints, appeals and grievances procedures.

- **Medical, optical, disability, death and legal benefit appeals:** Send all requests for medical, optical, death or legal benefit claim appeals to the Board of Trustees at:

  Board of Trustees
  Operating Engineers Local 30 Benefits Trust Fund
  115-06 Myrtle Avenue
  Richmond Hill, NY 11418

  Your request for review must be made in writing to the organization making the initial claims determination within 180 days after you receive notice of denial for health care, or 60 days after you receive notice of denial for life or AD&D insurance.

**Review Process**

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it falls into any of the following categories:

- The Plan relied on it in making the decision

- The Plan submitted, considered or generated it (regardless of whether it was relied upon)
• It demonstrates compliance with the Plan’s administrative processes for ensuring consistent decision-making.

• It constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that you may submit.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

**Timing of Notice of Decision on Appeal**

You will be sent a notice of decision on review within the following timeframes:

• **Pre-Service Claims:** within 15 days of receipt of the appeal by MedReview. If you are dissatisfied with the outcome of your first appeal, you may file another appeal with MedReview within 180 calendar days from the date on the notice of the letter denying your first appeal. You will be sent a notice of decision on review of your second appeal within 15 business days from MedReview’s receipt of the second appeal.

• **Urgent Care Claims:** within 72 hours after MedReview receives your appeal.

• **Post-Service Claims:** Ordinarily, decisions on appeals involving Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

**Notice of Decision on Review**

The Plan will notify you in writing of its decision on your appeal of a denied claim. This notice will state:

• Information sufficient to identify the claim involved, for example, the date of service, health care provider, claim amount (if applicable);

• A statement that you may receive, upon request and free of charge, the diagnosis code and/or the treatment code, and their corresponding meanings; however, such a request will not be treated as a request for external review;

• The specific reason(s) for the determination, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;

• 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;

• 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 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; and

• A disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

Please note that you may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than three years after the end of the year in which the services were provided.
Empire BlueCross BlueShield
Complaints, Appeals and
Grievances Procedures

Complaints: If you have a complaint (i.e., a verbal or written statement of dissatisfaction where Empire is not being asked to review and overturn a previous determination), call Member Services. If the complaint is too complex to be handled over the telephone, you can put your complaint in writing and mail it to:

Empire BlueCross Blue Shield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Member Services

If your complaint concerns behavioral health care, call (800)342-9816 or write to Empire Behavioral Health Services, 370 Bassett Road Bldg. 3, 2nd Floor, North Haven, CT 06473.

Standard complaints will be resolved within 30 days of receiving all necessary information. Expedited complaints will be resolved within 72 hours of receiving all necessary information. If you are not satisfied with Empire’s decision, you may file a grievance as described later in this section.

Appeals: If Empire denies a claim, in whole or in part, you may appeal that decision. Empire will provide written notice of why the claim was denied and your right to appeal the decision. You have 180 days to appeal. You or your authorized representative may submit a written request for review. You may ask for a review of pertinent documents and you may also submit a written statement of issues and comments. The claim will be reviewed and a decision will be made within 60 days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed 120 days after the appeal is received. The decision will be in writing and contain specific reasons for the decision.

Utilization Review: Empire has a Utilization Review process to review medical services provided to you to determine whether the services were medically necessary. Utilization Review is conducted by:

- Trained administrative personnel, under the supervision of a trained health care professional;
- A trained health care professional; and
- Where the review involves an adverse determination, a clinical peer reviewer. A clinical peer reviewer is a licensed physician or other licensed, certified or appropriately credentialed professional, who is in the same profession and same or similar specialty as a health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review.

Notification: All services are subject to retrospective review to determine if they were medically necessary. If Empire determines retrospectively that the service was not medically necessary, it will notify you in writing within 30 days of their receipt of the information necessary to render a decision and you will be liable for any service which they determine, in their sole judgment, to be medically unnecessary.

A notice of an adverse determination will be in writing and will indicate the reason for the determination, including the clinical rationale if any, for the determination; instructions on how to make a standard or external appeal; notice of the availability upon your request or the request of your designated representative, of the clinical review criteria relied on to make the determination. The notice will also specify what, if any, additional necessary information must be provided to or obtained by Empire in order to make a decision on appeal.

In the event that Empire renders an adverse determination without attempting to discuss the matter with the member’s health care provider who specifically recommended the health care service, procedure or treatment under review, the health care provider will have the opportunity to request a reconsideration of the adverse determination. Except in cases of retrospective review, such reconsideration will occur within one business day of receipt of the request and will be conducted by the member’s health care provider and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer cannot be available.

In the event that the adverse determination is upheld after reconsideration, Empire will provide written notice and documentation. Failure by Empire to make a determination within these time frames will be considered an adverse determination subject to appeal as described above.

Standard Appeal: If you disagree with the Utilization Review decision, you have the right to appeal the decision. The appeal may also be made by your designee or health care provider. You or your authorized representative may file a formal appeal by telephone or in writing. The notice of the appeal’s final determination will include:

- The reasons for the determination; provided, however, that where the adverse determination is upheld on appeal, the notice shall include the clinical rationale for such final adverse determination; and
- A notice of the covered person’s right to an external appeal together with a description of the external appeal process and time frames.
Appeals will only be conducted by clinical peer reviewers, provided that any such appeal will be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

**Level 1 Appeals:** A Level 1 Appeal is your first request for review of the initial reduction or denial of services. You have 180 calendar days from the date of the notification letter to file an appeal. An appeal submitted beyond the 180-calendar-day limit will not be accepted for review.

If the services have already been provided, Empire will acknowledge receipt of your appeal in writing within 15 calendar days from the initial receipt date.

Qualified clinical professionals who did not participate in the original decision will review your appeal.

Empire will make a decision within the following time frames for Level 1 Appeals.

- **Pre-certification.** Empire will complete its review of a pre-certification appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.
- **Concurrent.** Empire will complete its review of a concurrent appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.
- **Retrospective.** Empire will complete its review of a retrospective appeal within 30 calendar days of receipt of the appeal.

Empire will provide a written notice of its determination to you or your representative, and your provider, within two business days of reaching a decision.

If you are dissatisfied with the outcome of your Level 1 Appeal, you have the right to file a Level 2 Appeal.

If Empire’s Medical Management Program does not make a decision within the appropriate time frame listed above, Empire will approve the service.

**Expedited Level 1 Appeals:** You can file an expedited Level 1 Appeal and receive a quicker response if:

- You want to continue health care services, procedures or treatments that have already started.
- You need additional care during an ongoing course of treatment.
- Your provider believes an immediate appeal is warranted because delay in treatment would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Expedited Appeals may be filed by telephone and in writing.

Please note that appeals of claims decisions made after the service has been provided cannot be expedited. When you file an expedited appeal, Empire will respond as quickly as possible given the medical circumstances of the case, subject to the following maximum time frames:

- You or your provider will have reasonable access to Empire’s clinical reviewer within one business day of Empire’s receipt of the request.
- Empire will make a decision within two business days of receipt of all necessary information, but in any event within 72 hours of receipt of the appeal.
- Empire will notify you immediately of the decision by telephone, and within 48 hours in writing.

If you are dissatisfied with the outcome of your Level 1 Expedited Appeal, you may request an external review by a New York State Department of Insurance appeals agent.

**Level 2 Appeals and Time Frames:** If you are dissatisfied with the outcome of your Level 1 Appeal, you may file a Level 2 Appeal with Empire within 60 business days from the receipt of the notice of the letter denying your Level 1 Appeal. If the appeal is not submitted within that time frame, Empire will not review it and its decision on the Level 1 Appeal will stand. Appeals may be filed by telephone and in writing.

Empire will make a decision within the following time frames for Level 2 Appeals:

- **Pre-certification.** Empire will complete its review of a pre-certification appeal within 15 calendar days of receipt of the appeal.
- **Concurrent.** Empire will complete its review of a concurrent appeal within 15 calendar days of receipt of the appeal.
- **Retrospective.** Empire will complete its review of a retrospective appeal within 30 calendar days of receipt of the appeal.

**Level 1 Grievances.** A grievance is a verbal or written request for a review of an adverse determination concerning an administrative decision not related to medical necessity. The types of decisions that may be reviewed through the grievance process include denials of a request for a referral to an Out-of-Network provider, benefit denials based on a specific limitation in the subscriber contract (e.g., no pre-certification was obtained), and complaint decisions where the member disagrees with Empire’s findings.
A Level 1 Grievance is your first request for review of Empire’s administrative decision. You have 180 calendar days from the receipt of the notification letter to file a grievance. A grievance submitted beyond the 180-calendar day limit will not be accepted for review.

If the services have already been provided, Empire will acknowledge your grievance in writing within 15 calendar days from the date Empire received your grievance. The written acknowledgement will include the name, address, and telephone number of the department that will respond to the grievance, and a description of any additional information required to complete the review.

A qualified representative (including clinical personnel, where appropriate) who did not participate in the original decision will review your grievance.

We will make a decision within the following time frames for Level 1 Grievances:

- **Pre-service (services have not yet been rendered).** Empire will complete its review of a pre-service grievance (other than an expedited grievance) within 15 calendar days of receipt of the grievance.
- **Post-service (services have already been rendered).** Empire will complete its review of a post-service grievance within 30 calendar days of receipt of the grievance.

**Decisions on Grievances.** Empire’s notice of its Grievance decision (whether standard or urgent) will include:

- The reason for Empire’s decision, or a written statement that insufficient information was presented or available to reach a determination,
- The clinical rationale, if appropriate, and
- For Level 1 Grievances, instructions on how to file a Level 2 Grievance if you are not satisfied with the decision.

**Level 2 Grievances.** If you are dissatisfied with the outcome of your Level 1 Grievance, you may file a Level 2 Grievance with Empire. Empire must receive your request for a Level 2 Grievance by the end of the 60th business day after you receive its notice of determination on your Level 1 Grievance. If the Level 2 Grievance is not submitted within that time frame, Empire will not review it and the decision on the Level 1 Grievance will stand. Empire will acknowledge receipt of the Level 2 Grievance within 15 days of receiving the grievance.

The written acknowledgement will include the name, address and telephone number of the department that will respond to the grievance. A qualified representative (including clinical personnel, where appropriate) who did not participate in the Level 1 Grievance decision will review the Level 2 Grievance.

Empire will make a decision within the following time frames for Level 2 Grievances:

- **Pre-service.** Empire will complete its review of a pre-service grievance within 15 calendar days of receipt of the grievance.
- **Post-service.** Empire will complete its review of a post-service grievance within 30 calendar days of receipt of the grievance.

**Expedited Grievances.** You can file an expedited Level 1 or Level 2 Grievance and receive a quicker response if a delay in resolution of the grievance would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Expedited Grievances may be filed by telephone and in writing. When you file an expedited grievance, Empire will respond as soon as possible considering the medical circumstances of the case, subject to the following maximum time frames:

- Empire will make a decision within 48 hours of receipt of all necessary information, but in any event within 72 hours of receipt of the grievance.
- Empire will notify you immediately of the decision by telephone, and within two business days in writing.

**Coverage.** Empire will not provide coverage for any service that is not a covered service under your contract.

**How to File an Appeal or Grievance.**
To submit an appeal or grievance, call Member Services at (800) 553-9603, or write to one of the following addresses with the reason why you believe Empire’s decision was wrong. Please submit any data to support your request and include your member ID number and, if applicable, claim number and date of service.

The address for filing an appeal or grievance is:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

If your grievance or appeal concerns behavioral health care, call (800) 342-9816 or write to:

Empire Behavioral Health Services
370 Bassett Road Bldg. 3, 2nd Floor
North Haven, CT 06473

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

If your grievance or appeal concerns behavioral health care, call (800) 342-9816 or write to:

Empire Behavioral Health Services
370 Bassett Road Bldg. 3, 2nd Floor
North Haven, CT 06473
External Review for Claim Denied on Appeal (Empire BlueCross BlueShield Hospital Claims)

If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative must contact the Claims Administrator to:

- Any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Empire BlueCross Blue Shield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Member Services

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

External Review of Standard (Non-Urgent) Claims.

Your request for external review of a standard (not urgent) claim must be made, in writing, within four (4) months of the date that you receive notice of an initial claim or adverse appeal. For convenience, these determinations are referred to below as an “Adverse Determination,” unless it is necessary to address them separately.

An external review request on a standard claim should be made to the following applicable Plan designees:

- For PPO Medical and Prescription Drug claims, contact:
  Board of Trustees
  Operating Engineers Local 30 Benefits Trust Fund
  115-06 Myrtle Avenue
  Richmond Hill, NY 11418

The denial is due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, this external review process does not pertain to claims for life/death benefits, AD&D, disability or legal benefits.

Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on appeal.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

External Review for Claim Denied on Appeal (Non-Hospital Claims)

This External Review process is intended to comply with the Affordable Care Act (ACA) external review requirements.

You may seek further, external review by an Independent Review Organization (“IRO”), if your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim, is denied and it fits within the following parameters:

- The denial involves medical judgment, including but not limited to, those based on the Plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and/or
For EPO claims, contact:

CIGNA Open Access Plus
Customer Service
1-800-CIGNA24

The customer service representative will send an external review request form to fill out and return to CIGNA.


1. Within five (5) business days of the Plan’s receipt of your request for an external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

(a) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retroactive review, were covered under the Plan at the time the health care item or service was provided;

(b) The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan; your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage.

(c) You have exhausted the Plan’s internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and

(d) You have provided all of the information and forms required to process an external review.

2. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

(a) If your request is complete and eligible for external review; or

(b) If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number (866) 444-EBSA (3272)).

(c) If your request is incomplete, the notice will describe the information or materials needed to complete the request, and allow you to complete the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.


1. If the request is complete and eligible for an external review, the Plan or appropriate Plan designee will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

(a) The assigned IRO will timely notify you in writing of the request’s eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).

(b) Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

(c) If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms
of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan’s requirements for benefits, including the Plan’s standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan’s applicable clinical review criteria and/or the opinion of the IRO’s clinical reviewer(s).

(e) The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.

1) If the IRO’s final external review reverses the Plan’s Adverse Determination, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO’s decision.

2) If the final external review upholds the Plan’s Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

(f) The assigned IRO’s decision notice will contain:

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

2) The date that the IRO received the request to conduct the external review and the date of the IRO decision;

3) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

4) A discussion of the principal reason(s) for the IRO’s decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

5) A statement that the IRO’s determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable state or federal law);

6) A statement that judicial review may be available to you; and

7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

External Review of Expedited Urgent Care Claims.


You may request an expedited external review if:

1. you receive an adverse initial claim determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

2. you receive an adverse appeal determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse appeal determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Your request for an expedited external review of a non-standard claim should be made to the following applicable Plan designee:

MedReview
1 Seaport Plaza
199 Water Street
New York, NY 10038
B. Preliminary Review for an Expedited Claim.

Immediately upon receipt of the request for expedited external review, MedReview will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). MedReview will immediately notify you (e.g. telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).


Following the preliminary review that a request is eligible for expedited external review, MedReview will assign an IRO (following the process described under Standard Review above). MedReview will expeditiously (e.g. by telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan’s requirements for benefits, including the Plan’s standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements, set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice of the IRO’s decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

1. If the IRO’s final external review reverses the Plan’s Adverse Determination, upon the Plan’s receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO’s decision.

2. If the final external review upholds the Plan’s Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

Incompetence

In the event it is determined that a claimant is unable to care for his affairs because of illness, accident or incapacity, either mental or physical, any payment due may, unless claim has been made therefore by a duly appointed guardian, committee or other legal representative, be paid to the spouse or such other object of natural bounty of the claimant or such person having care and custody of the claimant or such person having the claimant’s power of attorney, as the Board of Trustees will determine in its sole discretion.
**Cooperation**

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

**Mailing Address**

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

**Recovery of Overpayment**

If you are overpaid or otherwise paid in error for a claim, you must return the overpayment. The Board of Trustees will have the right to recover any benefit payments made in reliance on any false or fraudulent statement, information or proof submitted, as well as any benefit payments made in error. Amounts recovered may include interest and costs.

In the event you are overpaid, the Fund Office will request a refund or the overpayment will be deducted from future benefits. Likewise, if payment is made on the eligible Plan participant’s behalf to a hospital, doctor or other provider of health care and that payment is found to be an overpayment, the Fund will request a refund of the overpayment from the provider. If the refund is not received, the amount of the overpayment will be deducted from future benefits, or a lawsuit may be initiated to recover the overpayment.

**No Fault Coverage**

This Plan will be considered SECONDARY to no-fault coverage even if you elect to reduce your premium by naming the Plan as primary.
OTHER INFORMATION YOU SHOULD KNOW

Coordination of Benefits

Members of a family are often covered by more than one group health insurance plan. As a result, two or more plans may provide coverage for the same expense. To determine which plan pays first, the Plan follows a Coordination of Benefits (COB) provision.

Coordination of benefits operates so that one of the plans (called the “primary plan”) pays benefits first. The secondary plan may then pay additional benefits. Here’s how the order of payment between the two plans is determined.

Employee/Dependent. The plan that covers you as an employee is primary, and the plan that covers you as a Dependent is secondary. If you are insured as an active employee under both plans, the plan that has provided coverage for you the longest will be the primary plan.

Dependent child/parents not divorced or separated. If a Dependent child is covered under both parents’ plans, the plan of the parent whose birthday is earlier in the year will pay first (this is often referred to as the “birthday rule”). For example, if one parent was born on August 4 and the other parent was born on November 11, the plan of the parent born on August 4 is primary because August 4 is earlier in the year. If the parents have the same birthday, the plan that covers a parent longer will pay first.

Dependent child/parents divorced or separated. If a plan has received notice of a Qualified Medical Child Support Order (QMCSO) that orders one of the parents to provide coverage, the plan indicated in the QMCSO will pay first. If there is no QMCSO, the plan of the parent with custody of the child pays benefits first. If the parent with custody remarries, then the primary plan will be that of the natural parent, the secondary plan will be the plan of the stepparent, and lastly, the plan of the natural parent who does not have custody will pay last.

What the Fund pays when it is secondary. When the Fund pays second, it will pay, with respect to the total benefits under each claim submitted for payment, no more than 100% of allowable expenses, minus whatever payments were actually made by the plan (or plans) that paid first.

Understanding what’s meant by “allowable expense.” An allowable expense means a necessary, reasonable and customary health care service or expense (including deductibles, coinsurance or copays) that is covered in full or in part by any of the plans covering the patient, except as provided below or where a statute applicable to the Fund requires a different definition. This means that an expense or service (or any portion of an expense or service) not covered by any of the plans is not an allowable expense.

Administration of COB. The Fund reserves the right to do the following in order to administer the COB provisions: exchange information with other plans involved in paying claims; require that you or your health care provider furnish any necessary information; reimburse any plan that made payments this Fund should have made; and recover any overpayment from your hospital, physician, dentist or other health care provider, other insurance company, you or your Dependent.

If the Fund should have paid benefits that were paid by any other plan, it may pay the party the amount the Board of Trustees (or its designee) determines to be proper under the COB provision. Any amounts so paid will be considered to be Fund benefits, and the Fund will be fully discharged from any liability it may have to the extent of such payment.

Coordination of medical benefits with Medicare. There are special rules for coordinating your Benefits Trust Fund medical benefits with benefits you might be entitled to under Medicare. The order of payment between Medicare and the Fund is as follows.

- Once you reach age 65, you are eligible for Medicare benefits, even if you are still working. You can delay your enrollment in Medicare until you retire. However, it may be to your advantage to sign up for Medicare when you first become eligible at age 65, since Medicare coverage would be available to you during periods of unemployment.
You must apply for Medicare at your local Social Security office at least three months before you reach age 65 to have your coverage become effective when you reach age 65.

- If you enroll in Medicare as an active employee, you may choose whether Medicare or the Fund will be your primary insurer. If you elect the Fund as your primary insurer, the Plan will pay benefits first and Medicare will pay second. If you elect the Fund as your primary insurer, you and your covered spouse age 65 or older will have the same coverage as any other active employee and covered spouse as long as you remain eligible under the Fund’s eligibility rules. If, however, you elect Medicare as your primary insurer, by law, your Fund coverage must end.

- If you become Totally Disabled and entitled to Medicare because of your disability, you will no longer be considered to remain actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second.

- If, while you are actively employed, you or any of your covered Dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Coordination with Medicaid. If your eligible Dependent(s) have coverage from the Fund and Medicaid, the Fund will be the primary insurer.

Coordination with TRICARE. If both the Fund and TRICARE cover you and/or your Dependent(s), the Plan pays first, and TRICARE provides secondary coverage.

Motor vehicle no-fault coverage required by law. If you and/or your Dependent(s) are covered for medical benefits by both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Plan pays second.

Other coverage provided by state or federal law. If you and/or your Dependent(s) are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first, and the Plan pays second.

Coordination with Workers’ Compensation. If you’re receiving benefits for a particular condition through Workers’ Compensation insurance or a similar program, Workers’ Compensation provides your primary and only coverage for that particular condition. Plan coverage remains in effect, excluding coverage for the particular condition that warranted Workers’ Compensation benefits.

Subrogation

The following section describes the rules that apply should another source, such as an automobile insurance company, be responsible for medical expenses that have already been reimbursed by the Plan. This may happen, for example, if you are in an automobile accident and receive medical treatment as a result.

The Plan helps you pay your medical expenses. If a third party or other source makes payments relating to a sickness or injury for which benefits have already been paid under the Plan, then the Plan is entitled to recover the amount of those benefits. You may be required to sign a reimbursement agreement if you seek payment of medical expenses relating to the sickness or injury under the Plan before you have received the full amount you would recover through a judgment, settlement, insurance payment or other source. In addition, you may be required to sign necessary documents and to promptly notify the Plan of the details of relevant legal actions.

The Plan shall have the right to, and in all cases, will seek to recover from you, your Dependents and/or any other person, entity or trust in possession of such funds sought by the Plan, all benefits paid by the Plan for injuries or disabilities for which monies are recovered in a claim or lawsuit or settlement. The Plan may seek such recovery through subrogation and/or any other equitable or legal relief available under state and/or federal law.

If you and/or your eligible Dependents are injured as a result of negligence or other wrongful acts, whether caused by you, your Dependents, or by a third party, and you and/or your Dependents apply to this Plan for benefits and receive such benefits, this Plan shall then have a first priority lien for the full amount of the benefits that are paid to you and/or your Dependents should you seek to recover any monies from any third party that caused, contributed to or aggravated the injuries or from any other source otherwise responsible for payment thereof. These monies may come directly from an insurance company, a third party or his or her insurance company, or any other source (including, but not limited to, any person, corporation, entity, uninsured motorist coverage, personal umbrella coverage, medical payments coverage, Workers’ Compensation coverage, or no-fault automobile coverage, or any other insurance policy or fund). The Plan’s lien arises through operation of the Plan. No additional subrogation or restitution agreement is necessary. The Plan’s lien is a lien on the proceeds of any compromise, settlement, judgment and/or verdict received from your insurance carrier, a third party and/or his insurance carrier, any other party settling on a third party’s or your behalf, or any other responsible source.

By applying for and receiving benefits under the Plan, you agree:
To restore to the Plan the full amount of the benefits that are paid to you and/or your Dependents from the proceeds of any such compromise, settlement, judgment and/or verdict, to the extent permitted by law;

That the proceeds of any compromise, settlement, judgment and/or verdict received from a third party, an insurance carrier, any other source and/or any other party settling on your or a third party’s behalf, if paid directly to you (or to such other person or entity), such proceeds will be held by you (or such other person or entity) in constructive trust for the Plan. The recipient of such funds is a fiduciary of the Plan with respect to such funds and is subject to the fiduciary provisions and obligations of ERISA. The Plan reserves the right to seek recovery from such person, entity or trust and to name such person, entity or trust as a defendant in any litigation arising out of the Plan’s subrogation or restitution rights;

That any lien the Plan may seek will not be reduced by any attorney fees, court costs or disbursements that you and/or your attorney might incur in an action to recover from a third party or any other source, and these expenses may not be used to offset your obligation to restore the full amount of the lien to the Plan; and

That any recovery will not be reduced by and is not subject to the application of the common fund doctrine for the recovery of attorney’s fees.

The Plan strongly recommends that if you are injured as a result of the negligence or wrongful act of a third party, or if injuries resulted from your own acts, or the acts of your Dependents, you should contact your attorney for advice and counsel. However, this Plan cannot and does not pay for the fees your attorney might charge. The Plan does not require you to seek any recovery whatsoever against the third party or any other source, and if you do not receive any recovery, you are not obligated in any way to reimburse the Plan for any of the benefits that you applied for and accepted. However, in the event that you do not pursue any and all third parties or any other responsible sources, you authorize the Plan to pursue, sue, compromise or settle (in the Plan’s discretion) any such claims on your behalf and you agree to execute any and all documents necessary to pursue said claims, and you agree to fully cooperate with the Plan in the prosecution of any such claims.

Should you seek to recover any monies from any third party or any other source that caused, contributed to, aggravated your injuries, or is otherwise responsible, it is a rule of this Plan that you must give notice in writing of same to the Plan Administrator within ten days after either you or your attorney first attempt to recover such monies, or institute a lawsuit, or enter into settlement negotiations with another or take any other similar action. You must also cooperate with the Plan’s reasonable requests concerning the Plan’s subrogation and restitution rights and keep the Plan informed of any important developments in your action. You must also provide the Plan with any information or documents, upon request, that pertain to or are relevant to your actions. If litigation is commenced, you are required to give at least five days written notice to the Plan prior to any action to be taken as part of such litigation, including, but not limited to, any pretrial conferences or other court dates. Representatives of the Plan reserve the right to attend such pretrial conferences or other court proceedings.

In the event you fail to notify the Plan as provided for above, and/or fail to restore to the Plan such funds as provided for above, the Plan reserves the right, in addition to all other remedies available to it at law or equity, to withhold or offset any other monies that might be due you from the Plan for past or future claims, until such time as the Plan’s lien is discharged and/or satisfied.

Any and all amounts received from any third party or any other source by judgment, settlement, or otherwise, must be applied first to satisfy your restitution obligation to the Plan for the amount of medical expenses paid on behalf of a member or beneficiary. The Plan’s lien is a lien of first priority for the entire recovery of funds paid on your behalf. Where the recovery from a third party or any other source is partial or incomplete, the Plan’s right to restitution takes priority over the member’s or beneficiary’s right of recovery, regardless of whether or not the member or beneficiary has been made whole for his or her injuries or losses. The Plan does not recognize and is not bound by any application of the “make whole” doctrine.

**Repayment of Medical Benefits**

Benefits payable by the Fund for the treatment of an illness or injury shall be limited in the following ways when the illness or injury is the result of an act or omission of another (including a legal entity) and when the participant or Dependent pursues or has the right to pursue a recovery for such act or omission.

The Fund shall pay benefits for covered expenses related to such illness or injury only to the extent not paid by the third party and only after the participant or Dependent (and his or her attorneys, if applicable) has entered into a written subrogation and reimbursement agreement with the Fund. Failure by the participant or Dependent to enter into such an agreement will not waive, compromise, diminish, release or otherwise prejudice any of the Fund’s subrogation and/or reimbursement rights.

By accepting benefits related to such illness or injury, you agree:

- That the Fund has established a lien on any recovery received by you (or your Dependent, legal representative or agent);
- To notify and consult with the Fund and the Fund Administrator (or its duly authorized designee) before starting any legal action or administrative proceeding that may relate to or involve recovery of any payments of Plan benefits.

- To notify any third party responsible for your illness or injury of the Plan’s right to reimbursement for any claims related to your illness or injury;

- To hold any reimbursement or recovery received by you (or your Dependent, legal representative or agent) in trust on behalf of the Fund to cover all benefits paid by the Fund with respect to such illness or injury and to reimburse the Fund promptly for the benefits paid, even if you are not fully compensated (“made whole”) for your loss and regardless of whether any proceeds received by you are characterized in the settlement or judgment as being paid on account of expenses for which Plan benefits were paid;

- That the Fund has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether or not the participant or Dependent is made whole) and that the Fund’s claim has first priority over all other claims and rights;

- To reimburse the Fund in full up to the total amount of all benefits paid by the Fund in connection with the illness or injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance or otherwise, must be turned over to the Fund as reimbursement up to the full amount of the benefits paid.

- That the Fund’s claim is not subject to reduction for attorney’s fees or costs under the “common fund” doctrine or otherwise;

- That, in the event that you elect not to pursue your claims) against a third party, the Fund shall be equitably subrogated to your right of recovery and may pursue your claims;

- To assign, upon the Fund’s request, any right or cause of action to the Fund;

- Not to take or omit to take any action to prejudice the Fund’s ability to recover the benefits paid and to cooperate in doing what is reasonably necessary to assist the Fund in obtaining reimbursement;

- To cooperate in doing what is necessary to assist the Fund in recovering the benefits paid or in pursuing any recovery, including, without limitation, keeping the Fund and the Fund Administrator (or its duly authorized designee) apprised of all material developments with respect to any relevant claims, actions or proceedings;

- To forward any recovery to the Fund within ten days of disbursement by the third party or to notify the Fund as to why you are unable to do so; and

- To the entry judgment against you and, if applicable, your Dependent, in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the Fund’s attorneys’ fees and costs.

No benefits will be payable for charges and expenses which are excluded from coverage under any other provision of the Plan. The Fund may enforce its right to reimbursement by filing a lawsuit, recouping the amount owed from a participant’s or a covered Dependent’s future benefit payments (regardless of whether benefits have been assigned by a participant or covered Dependent to the doctor, hospital or other provider), or any other remedy available to the Fund.

The Fund may permit you to turn over less than the full amount of benefits paid and recovered as it determines in its sole discretion. Any reduction of the Fund’s claim is subject to prior written approval by the Fund. The Fund shall have the right to recover from you, your Dependents (and/or any other person, entity or trust in possession of such funds sought by the Fund) all benefits paid on your or your Dependent’s behalf by the Fund for injuries or disabilities that you or your Dependents have suffered for which you or they recover money in a “third party” claim or lawsuit or settlement thereof. The Fund may seek such recovery through subrogation and/or any other equitable or legal relief available under state or federal law.

If you fail or refuse to sign a Lien Acknowledgement or to comply with the terms herein, then the Plan Administrator may suspend future payments to you, or recover from the providers money paid to them, or take all of the foregoing actions until the Fund is made whole. In addition, the Trustees of the Fund may bring a court action against you to enforce the terms of the Plan.

We recommend that, if you are injured as a result of the negligence or wrongful act of a third party, you contact your attorney for advice and counsel. However, this Plan shall not pay for the fees your attorney might charge.
Confidentiality of Health Care Information

The Plan is required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. The official HIPAA Privacy Notice, which is distributed to all participants of the Plan, is summarized here.

The intent of HIPAA is to make sure that private health information that identifies (or could be used to identify) you is kept private. This individually identifiable health information is known as “protected health information” (PHI). The Plan will not use or disclose your PHI without your written authorization except as necessary for treatment, payment, Plan operations and Plan administration, or as permitted or required by law. What’s more, the Plan will implement administrative, physical and technical safeguards to ensure that your PHI remains confidential, intact, secure and available only to authorized users. The Plan also will ensure that there are reasonable and appropriate security measures to protect electronic PHI, and ensure that any agent, including a subcontractor to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect the electronic PHI.

The Plan also hires professionals and other companies to advise the Plan and help administer and provide health care benefits. The Plan requires these individuals and organizations, called “Business Associates,” to comply with HIPAA’s privacy rules. In some cases, you may receive a separate notice from one of the Plan’s Business Associates (for example, Empire BlueCross BlueShield). That notice will describe your rights with respect to benefits administered by that individual/organization.

Under federal law, you have certain rights where your PHI is concerned, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, change or correct the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services, if you believe your rights have been violated.

If you have questions about the privacy of your health information or if you would like a copy of the official HIPAA Privacy Notice, please contact the Fund Office.

How Benefits May Be Reduced, Delayed or Lost

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

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

You should also be aware that Fund benefits are not payable for enrolled Dependents who become ineligible due to age, marriage or divorce (unless they elect and pay for COBRA benefits, described on page 8).

If any Plan mistakenly pays a bigger benefit than you’re eligible for, or pays benefits that were not authorized by the Plan, the Plan may seek any permissible remedy allowed by law to recover benefits paid in error (also see “Recovery of Overpayment,” page 84 and “Subrogation,” page 85).

Women’s Health and Cancer Rights Act of 1998 Notice

The Women’s Health and Cancer Rights Act of 1998 requires that all group medical plans that provide medical and surgical benefits with respect to a mastectomy must provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications associated with all stages of mastectomy, including lymphedemas.

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage is subject to applicable copays, referral requirements, annual deductibles and coinsurance provisions, depending on the medical plan option you elect. If you have any questions, please contact the Fund Office.

Compliance With Federal Law

The Plan is governed by regulations and rulings of the Internal Revenue Service and the Department of Labor, and current federal tax law. The Plan will always be construed to comply with these regulations, rulings and laws. Generally, federal law takes precedence over state law.
Amendment and Termination of the Plan

The Trustees of the Fund have the authority to amend or terminate the Plan at any time and for any reason. You will be notified if the Plan is amended or terminated; however, the change may be effective before a notice is delivered to you.

If the Plan is ended, Plan assets will be applied to provide benefits in accordance with the applicable provisions of federal law.

Your Disclosures to the Plan

If you provide false information to the Plan or commit fraud, you may be required to indemnify and repay the Plan for any losses or damages caused by your false statements or fraudulent actions. (Some examples of fraud include altering a check and knowingly cashing a voided check.) What’s more, if the Plan makes payments as a result of false statements or fraudulent actions, the Board of Trustees may elect to pursue the matter by pressing criminal charges.

Plan Administration

The Fund is a welfare benefit plan. Fund assets are accumulated under the provisions of the Trust Agreement and are held in a Trust Fund for the purpose of providing benefits to participants and defraying reasonable administrative expenses. The Fund is administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees with equal voting power.

Discretionary Authority of the Board of Trustees

The Board of Trustees governs the Fund in accordance with an Agreement and Declaration of Trust. The Trustees have the sole and absolute discretionary authority to interpret the terms of the Plan, determine benefit eligibility, and resolve ambiguities or inconsistencies in the Plan. All determinations and interpretations made by the Board of Trustees and/or its duly authorized designee(s) shall be final and binding upon all participants, beneficiaries and any other individuals claiming benefits under the Plan.

The Board of Trustees has delegated certain administrative and operational functions to the Fund Secretary and his/her staff. Most of your day-to-day questions can be answered by the Fund Office staff.

Employer Contributions

The Fund receives contributions according to collective bargaining agreements between your employer and Local Union 30 and its subdivisions of the International Union of Operating Engineers, AFL CIO. These collective bargaining agreements provide that employers contribute to the Fund on behalf of each covered employee on a specified basis. Certain other employers (such as the Fund Office itself) may participate in the Plan by signing a participation agreement.

To find out whether a particular employer is contributing to the Fund on behalf of members working under a collective bargaining agreement or a participation agreement and, if so, to which plan of benefits the employer is contributing, contact the Fund Office. You can look at the collective bargaining agreements at the Fund Office or get your own copy upon written request to the Fund Office.

Rescission of Plan Coverage

The Plan will not rescind your health coverage (including a group to which you belong or family coverage in which you are included) once you are covered under the Plan, unless you (or persons seeking coverage on your behalf) perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan, and in other instances that may be prescribed in the Treasury Regulations. For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if:

- It is attributable to a delay in administrative recordkeeping if you do not pay any premiums for coverage after termination of employment.
- It is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contribution toward the cost of coverage.
- It is effective retroactively to the date of divorce.

The Plan is required to provide at least 30 days advance written notice to each Participant who is affected by a rescission of coverage before the coverage may be rescinded, regardless of whether the rescission applies to an entire group or only to an individual within the group. A rescission is also a type of adverse benefit determination of a health plan claim as defined under the U.S. Department of Labor Regulations.
YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

Information About Your Plan and Benefits

As a participant in the International Union of Operating Engineers Local 30 Benefits Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Fund Office and at other specified locations, such as the union hall, all Plan documents, including collective bargaining agreements, and copies of all documents, such as detailed annual reports and Plan descriptions filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a “qualifying event.” You or your Dependents may have to pay for such coverage. The Fund recommends that you review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, 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 later enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a Plan benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
If you have a claim for benefits 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, you may file suit in a federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

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

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<tr>
<th>Official Plan Name</th>
<th>International Union of Operating Engineers Local 30 Benefits Trust Fund and Group Legal Services Trust Fund</th>
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<tbody>
<tr>
<td>Employer Identification Number (EIN)</td>
<td>11-2741909</td>
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<tr>
<td>Plan Number</td>
<td>501</td>
</tr>
<tr>
<td>Plan Year</td>
<td>January 1 – December 31</td>
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<tr>
<td>Type of Plan</td>
<td>Welfare Health Plan providing group comprehensive medical, prescription drug, vision, dental, disability and legal benefits.</td>
</tr>
<tr>
<td>Funding of Benefits</td>
<td>The Fund is funded through employer contributions pursuant to Collective Bargaining Agreements or other written documents.</td>
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<tr>
<th>Insured Benefits</th>
<th>Self-insured Benefits</th>
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<tbody>
<tr>
<td>Aetna DMO</td>
<td>Empire BlueCross BlueShield Hospital Benefits</td>
</tr>
<tr>
<td>Short-term Disability</td>
<td>MagnaCare Medical Benefits</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>CIGNA Open Access Plus EPO Benefits</td>
</tr>
<tr>
<td>Accidental Death &amp; Dismemberment Insurance</td>
<td>CVS Caremark Prescription Drug Benefits</td>
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<td>Laser Surgery Benefits</td>
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<td>Healthplex PPO Dental</td>
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<td>DDS, Inc. Dental</td>
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<td>Vision Benefits</td>
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<td>Legal Services</td>
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| Trust | Contributions to the International Union of Operating Engineers Local 30 Benefits Trust Fund and Group Legal Services Trust Fund are held in a trust pursuant to the Trust Agreement. |

| Plan Sponsor and Administrator | The Local 30 Benefits Trust Fund and Group Legal Services Trust Fund are sponsored and administered by a joint Board of Trustees. The office of the Board of Trustees may be contacted at: |

| Board of Trustees | The Local 30 Benefits Trust Fund and Group Legal Services Trust Fund 115-06 Myrtle Avenue Richmond Hill, NY 11418 (718) 847-8484 |

| Agent for Service of Legal Process | The Board of Trustees has been designated as the agent for the service of legal process. Legal process may be served at the Fund Office and on the individual Trustees. Legal service may also be served on insurers. |
KEY TERMS AND DEFINITIONS

It’s important that you understand how the following terms are defined for Plan purposes.

**Contributing Employer (employer)** is a person, company or other employing entity that has signed a Collective Bargaining Agreement or any other contractual agreement with the Union or Trust, and the agreement requires contributions to the Benefits Trust Fund for work in covered employment.

**Coinsurance** means the percentage you pay toward eligible expenses once the annual deductible is met.

**Coordination of Benefits (COB)** means the rules and procedures the Plan uses to determine how Plan benefits will be paid when a participant is covered by two or more employer-sponsored health care plans.

**Copayment** means the flat-dollar fee you pay for office visits and certain covered services when you use in-network providers. The Plan then pays 100% of remaining covered expenses.

**Covered Employment** is work for which your Contributing Employer is required to contribute to the Benefits Trust Fund. In general, “covered employment” refers to work in a job category covered by an International Union of Operating Engineers Local 30 Benefits Trust Fund contract, but it also can include other, non-contract job categories as long as your Contributing Employer voluntarily agrees to cover you under a written agreement Local 30.

**Covered Services** are the services for which claims administrators provide benefits under the terms of their contracts with the Plan.

**Deductible** means the dollar amount you must pay each calendar year before benefits become payable for covered Out-of-Network services.

**Dependent** means a member’s lawful spouse and unmarried children under age 26, as described on page 2.

**Enrollment Forms** are the forms that you must complete to enroll in the Plan.

**Fund Assets** consist of (1) the sums of money that have been or will be paid or which are due and owing to the Fund by the Employers as required by Collective Bargaining Agreements, (2) all investments made with, the proceeds of, and the income from that money, (3) all other contributions and payments to or due and owing to the Trustees from any source to the extent permitted by law and (4) supplies, property and other assets used by the Trustees in the administration of the Fund.

**Home Health Care Agency** is an organization, currently certified or licensed by New York State, that has entered into a contract with a Plan provider to render home health care services.

**Hospice** is a facility that provides a hospice care program. It operates as a unit or program that only admits Terminally Ill patients, and it is separate from any other facility. However, it may be affiliated with a hospital or home health care agency. The hospice must be approved by the Plan as meeting the legal requirements and be licensed by New York State.
In-Network Benefits means benefits for covered services delivered by In-Network providers and suppliers. Services provided must fall within the scope of their individual professional licenses.

Hospital is an institution that renders inpatient and outpatient services for the medical care of the sick or injured. It must be accredited as a hospital by either the Joint Commission on Accreditation of Health Care Facilities or the Bureau of Hospitals of the American Osteopathic Association. A Hospital may be a general, acute care, or specialty institution, provided that it is appropriately accredited as such, and currently licensed by the proper state authorities.

Medical Emergency means a condition whose symptoms are so serious that someone who’s not a doctor – but who has average knowledge of health and medicine – could reasonably expect that, without immediate medical attention, the following would happen:

- The patient’s health would be placed in serious jeopardy.
- There would be serious problems with the patient’s body functions, organs or parts.
- There would be serious disfigurement.
- The patient or those around him/her would be placed in serious jeopardy, in the event of a behavioral health emergency.

Medically Necessary means services, supplies or equipment that are all of the following:

- Provided by a hospital (other than a hospital clinic) or other provider of health services.
- Consistent with the symptoms or diagnosis and treatment of the patient’s condition, illness or injury.
- Meet the standards of good medical practice.
- Not solely for the convenience of the patient, the family or the provider.
- Not primarily custodial.
- The most appropriate level and type of service that can be safely provided to the patient.

The fact that a Network provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it medically necessary.

Network Provider means the same as “In-Network provider.”

Primary Care Physician is a Network physician who:

- Maintains continuity of patient care;
- Provides initial care and basic medical services;
- Initiates referrals for specialty care; and
- Participates in the Plan’s Network.

Provider means a hospital, facility or other appropriately licensed or certified professional health care practitioner. The Plan will pay benefits only for covered services within the scope of the practitioner’s license.

Reasonable and Customary Charge (R&C) is a charge that is the normal charge (or “going rate”) made by the provider for a similar service or supply in a geographic area. To determine if a charge is reasonable and customary, the Plan will take into account the nature and severity of the illness or injury being treated.

Skilled Nursing Facility is a licensed institution (or a distinct part of a hospital) that is primarily engaged in providing continuous skilled nursing care and related services for patients who require medical care, nursing care or rehabilitation services.
**Specialist** is a licensed physician whose practice is limited to a particular branch of medicine or surgery and based upon advanced training is certified by a specialty board as being qualified to limit his or her practice.

**Specialized Rehabilitation Facility** is a hospital or other facility that is certified by either the New York division of Alcoholism and Alcohol Abuse or the division of Substance Abuse Services for the treatment of alcohol or drug dependent individuals, respectively. It provides nursing, medical counseling, and therapeutic services to such individuals according to individualized treatment plans. Such facilities must be contracted with the Plan in order for members to receive covered services. Transitional living facilities are excluded.

**Totally Disabled** is a member who is prevented because of injury or disease from performing his or her regular or customary occupational duties and is not engaged in any work or other gainful activity for pay or profit. A covered Dependent who is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex, who is in good health.

**Uniformed Services** means the United States Armed Forces; Army National Guard; Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty; commissioned corps of the Public Health Service; and any other category of persons designated by the President in time of war or emergency.

**Urgent Care** is medical care for a condition that needs immediate attention to minimize severity and prevent complications, but is not a medical emergency. Urgent Care may be rendered in a physician’s office or Urgent Care center.

**Urgent Care Center** is a licensed facility (except hospitals) that provides Urgent Care.