1199 New England Health Care Employees WELFARE FUND

Dear Welfare Fund Participant:

We are pleased to provide you with this summary plan description (SPD) which explains the benefits provided by the New England Health Care Employees Welfare Fund (the "Fund"). This booklet and the plan provisions described within it replace all previous materials regarding your benefits provided by the Fund. All information in this SPD is current as of the date of publication of this booklet, January 2007. For the latest benefit information please visit the Welfare Fund's website or call the Fund Office.

The Fund was established by your union, the New England Health Care Employees Union, District 1199, SEIU, and a group of employers in New England with whom District 1199 has collective bargaining agreements. The Fund is financed by participating employers who have contracts with the Union. The Fund is administered by a Board of Trustees (the "Trustees"), consisting of an equal number of Trustees appointed by the Union and by employers who make payments to the Fund on behalf of their workers.

This booklet serves as both an SPD and Plan Document for participants in the Fund. It is designed to make it easier for you to find the information you need and to understand your rights and responsibilities as a Fund participant. It is important that you read the entire booklet so that you know:

- the benefits you are eligible to receive
- the policies and procedures that must be followed to receive your benefits
- how to use your benefits wisely

Fund benefits are subject to change by the Trustees in their sole discretion. The Trustees have the sole and final authority to determine eligibility for benefits and to interpret and apply the terms of the plan.

If you have any questions or concerns about any of your benefits or coverage for a specific medical problem, call the Fund Office:

Toll free: 1-800-227-4744
Hartford area: 860-728-1100

The Fund staff will be happy to assist you.

With your help, the Fund can continue to provide a comprehensive package of health care benefits in the years ahead for you and your family and other Fund participants and their families.

The Board of Trustees
January, 2007

Help in Other Languages

This booklet describes your rights and benefits under the New England Health Care Employees Welfare Fund.

If you have difficulty understanding any part of this booklet, you should contact the Fund Office for assistance. You can come to the office in person or call to speak with a Fund representative.

If you are visiting the Fund Office or mailing material to the Fund, our address is:

New England Health Care Employees Welfare Fund
77 Huyshope Avenue, 2nd Floor
Hartford, Connecticut 06106-7001

Office hours are Monday through Friday 9:00 a.m. to 5:00 p.m.

You may stop in or call the Fund Office at any time during office hours:

Toll-free, at 1-800-227-4744
Hartford area, 860-728-1100

Asistencia en otros idiomas

Este folleto describe sus derechos y beneficios según se especifican en el Fondo de bienestar para los empleados del New England Health Care Employees Welfare Fund.

Si usted tiene dificultad para entender cualquier parte de este folleto, puede comunicarse con la Oficina del Fondo de bienestar para conseguir asistencia. También puede venir a la oficina en persona o llamar y pedir hablar con un representante del Fondo de bienestar.

Si viene a la Oficina de Fondo de bienestar, o si va a enviar algún documento por correo al Fondo de bienestar, nuestra dirección es la siguiente:

New England Health Care Employees Welfare Fund
77 Huyshope Avenue, 2nd Floor
Hartford, Connecticut 06106-7001

Nuestras horas de oficina son de Lunes a Viernes 9:00 a.m. - 5:00 p.m.

Usted puede pasar por aquí o llamar a la Oficina del Fondo de bienestar en cualquier momento durante las horas de oficina:

Llamada sin cargo, 1-800-227-4744
En el área de Hartford, 860-728-1100

TABLE OF CONTENTS

INTRODUCTION TO YOUR FUND COVERAGE

ELIGIBILITY AND ENROLLMENT

YOUR HEALTH CARE BENEFITS

YOUR OTHER BENEFITS

YOUR HEALTH CARE BENEFITS

IMPORTANT INFORMATION

This booklet was designed to help you to understand important information about your Fund coverage. Please take the time to read the entire booklet and keep it handy for future reference.

While the booklet covers detailed and often complex issues, it has been written in a simple and direct way to help you and your family better understand your benefits and what your rights and responsibilities are. Please keep in mind that this section is a summary and the actual terms and conditions of your coverage are defined in greater detail throughout this booklet.

Helpful Tools

Throughout the booklet you will see different tools in the left hand margin and in the text. They include:

- Checklists
- Highlights
- Contact Information, and
- Important Terms

These tools point out and summarize critical information, procedures or phone numbers that you and your family need to know in order to understand, among other things:

- what benefits you are eligible for
- when you need to pre-certify or provide notice of your care in order to avoid penalties
- who you should contact for more information

Throughout the Medical section you will see a phone icon with the letters, "PC" for Pre-certification. This means that you, a family member or your physician must call the Medical Utilization Review vendor to pre-certify the proposed treatment.

Throughout the Medical section you will also see a phone icon with the letter, "N" for Notification. This means that you, a family member or your physician must call the Medical Utilization Review vendor to notify them of your status and care.

There are other health care situations where you are required to notify the Medical Utilization Review vendor or the Fund Office. For more information, see the *How to Access Services* section, page 25.

General Terms

Who Are "You"?

Important Term

The word "**you**" is used throughout this booklet. This refers to you, the employee represented by District 1199 and an eligible Fund participant. You, as the Fund participant, are the person who has rights to these health and welfare benefits — coverage that may extend to family members who are eligible for coverage based on your wage class and your average weekly hours worked.

Who Is "Your Spouse"?

Important Term

Generally, whenever the term "**your spouse**" is used in this booklet, it not only refers to a husband or wife but to a partner in a legally recognized same-sex relationship as well — unless specifically noted or it is clear from its context that "your spouse" means only a husband or wife.

Who Is "Your Dependent Child"?

Important Term

Generally, the term "**dependent child**" means your dependent child for whom you have an established legal obligation to support and you are either the child's biological parent, have legally adopted the child or, in some cases, have begun adoption proceedings.

Coverage Basics

Your coverage is provided to you under your Union contract with your employer, at no cost to you. However, you do share the cost of most covered health care services with the Fund in the following ways:

- ✔ You are responsible for paying for covered health care services up to your annual deductible amount — $250 In-network, $500 Out-of-Network
- ✔ Once you meet your annual deductible:
  - ❖ the Fund pays 80% of in-network covered services and benefits, up to the network-allowed charge, and
  - ❖ you pay the remaining 20% of in-network covered services, known as your co-insurance amount
- ✔ Your annual deductible and any co-insurance payments are applied toward your $1,250 Annual Individual/Family Out-of-Pocket Maximum.
- ✔ Once your out-of-pocket expenses for covered medical services reach the annual out-of-pocket maximum, the Fund pays 100% of covered services, up to the network-allowed charge, to a $200,000 Annual Maximum.
- ✔ For your prescription drugs, you must make a co-pay. This is your only expense for the prescription drugs as the Fund pays 100% of the remaining charge.
- ✔ There are separate deductibles and co-payments for your dental benefit. The maximum benefit is $1,000 per person per calendar year.

For more information, see the *You Share the Cost* section, page 35.

Your Benefit Level

There are three wage classes with different Fund benefit levels: Wage Class I, Wage Class II and Wage Class III. Your wage class and your average weekly hours worked determine what benefit level you and your eligible dependents can receive from the Fund.

Wage class is based on the wages you earn compared with the minimum full-time wage specified in the Union contract with your employer. For more information, see the *Terms of Eligibility* (page 11) and *How Your Benefit Level Is Determined* (page 17) sections.

Pre-certification / Notification

There are times when you, a family member or your doctor must place a phone call to the Fund or the Fund designee for you to qualify for coverage, including:

- to pre-certify certain health care services, and
- to notify the Fund if you or a covered dependent is hospitalized on an emergency basis

Pre-certification

Important Term

To meet the Fund's **pre-certification** requirements, you must contact the Medical Utilization Review vendor **before** going to the hospital for a non-emergency admission. If you do not call you will have to pay a penalty of 20% of the hospital bill, up to a maximum of $500 per admission.

You must also contact the Medical Utilization Review vendor to pre-certify:

- all inpatient behavioral health treatment
- outpatient behavioral health treatment **after** the first 10 visits (per calendar year)
- behavioral health Intensive Outpatient Program (IOP) or Partial Hospital Program (PHP) **after** the first 10 days (per calendar year)

There are other health care services that require pre-certification. In some cases, benefits may not be paid if the pre-certification requirements are not met. The phone number for the Medical Utilization Review vendor can be found in the *Contact Information* section, page 6.

Highlights

In some cases, benefits may not be paid if the pre-certification requirements are not met.

Notification

Important Term

To meet the Fund's **notification** requirements, you must contact the Medical Utilization Review vendor within 48 hours of an emergency admission to the hospital. If you do not call you will have to pay a penalty of 20% of the hospital bill, up to a maximum of $500 per admission.

There are other health care services that require notification. For more on Pre-certification or Notification information, see the *How to Access Services* section, page 25.

Contact Information

Questions About Your Benefits

You should call the Fund Office at 860-728-1100 or, toll-free, at 1-800-227-4744 if you have any questions about your benefits or the programs or services offered by the Fund.

Prior Approval from the Fund

There are several medical services that require prior approval from the Fund Office. This means that **before** these services are performed, you or your health care provider must call the Fund Office at 860-728-1100 or, toll-free, at 1-800-227-4744. You should be familiar with which services require prior approval as it is your responsibility, not your health care provider's, to make sure that the required call is made. For a list of services requiring prior approval from the Fund, please see the *About Pre-Certification and Prior Approval* section, page 25.

Hospital Stay

You are required to call the Fund's Medical Utilization Review vendor, Hines & Associates, also listed on your Fund Medical ID Card, to pre-certify any inpatient hospitalization. You must:

- pre-certify your hospital stay before going to the hospital for non-emergency care, and
- notify Hines & Associates within 48 hours of an emergency hospital admission

Call Hines & Associates, the Medical Utilization Review vendor, toll-free, at 1-800-670-7718.

Behavioral Health (Mental Health and Substance Abuse)

You are required to contact the Medical Utilization Review vendor, Hines & Associates, also listed on your Fund Medical ID Card, to pre-certify:

- **all** inpatient behavioral health treatment
- outpatient behavioral health treatment **after** the first 10 visits (per calendar year)
- behavioral health Intensive Outpatient Program (IOP) or Partial Hospital Program (PHP) **after** the first 10 days (per calendar year)

Call Hines & Associates, the Medical Utilization Review vendor, toll-free, at 1-800-670-7718.

List of Network Providers

For a list of Network health care providers, hospitals and facilities, call the Fund Office or:

- call Anthem Blue Cross Blue Shield (BCBS) the Fund's Preferred Provider Organization (PPO), toll-free, at 1-800-810-BLUE (1-800-810-2583), or
- visit the Anthem BCBS website at www.Anthem.com

Prescription Drugs

To find a Network pharmacy in your area, call the Fund Office or Prescription Solutions, the Fund's Pharmacy Benefit Manager (PBM):

- call Prescription Solutions, toll-free, at 1-800-788-7871, or
- visit their website at www.rxsol.com

For the Mail Pharmacy Service for maintenance drugs, you should also call Prescription Solutions, toll-free, at 1-800-788-7871.

Dental Care

To receive a copy of the dental care benefits booklet call the Fund Office. If you have any questions, call Delta Dental's customer service phone number, toll-free, at 1-800-452-9310.

To find a Network dentist in your area, call the Fund Office or Delta Dental, the Fund's dental care provider:

- call, toll-free, 1-800-DELTA OK (1-800-335-8265), or
- visit the Delta Dental website at www.DeltaDentalNJ.com

Vision Care

If you have questions about the vision program, call the Fund Office or Davis Vision, the Vision Care Services provider, toll-free, at 1-800-999-5431.

To find a Network provider in your area, call the Fund Office or:

- call Davis Vision, toll free, 1-800-999-5431, or
- visit the Davis Vision website at www.DavisVision.com

Note:

This list of third party providers is current as of the booklet's publication date — January 2007 — and may change. You will be notified if there is a change in providers.

TERMS OF ELIGIBILITY

This section details the eligibility rules for coverage by the Fund.

To help you better understand eligibility for coverage, several summary charts have been included in this booklet. In addition, before each benefit section, the following chart is shown:

		YOU	SPOUSE	CHILDREN
Wage Class I	< 32	Y		
	≥ 32	Y	S	C
Wage Class II	< 32	Y		
	≥ 32	Y	S	C
Wage Class III		Y		

Y You, the Fund participant

S Your eligible spouse or eligible same-sex partner, and

C Your eligible dependent child(ren)

Who Is Eligible

To determine who is eligible for Fund coverage, first locate your wage class. If you are in Wage Class I or II, you need to determine if your average weekly hours worked are less than 32 — shown as < 32 — or 32 hours or greater — shown as ≥ 32. Based on these factors, you can then determine who is eligible for coverage:

You

You are eligible to participate in the Fund if you are an active employee who has completed the probationary period and your employer makes required contributions to the Fund on your behalf.

As a Fund participant, you may also be eligible for COBRA continuation coverage, as defined later in this booklet.

Your Spouse

Your spouse may be eligible for Fund benefits if:

- you and your spouse are married
- you are in Wage Class I or II, and
- you average at least 32 hours of work per week

For complete information, see the *How Your Benefit Level Is Determined* section, page 17.

If you and your spouse divorce, are legally separated or separated for more than one year, your former or separated spouse will no longer be an eligible dependent for purposes of coverage by the Fund, regardless of any agreement, court order or divorce decree.

If You Are a New Employee and Do Not Automatically Qualify For Dependent Coverage

If you are a new employee and do not qualify for dependent coverage you may be eligible for a one-time option to purchase dependent coverage. If this option is timely exercised, your dependent coverage is identical to dependent coverage for employees regularly working 32 or more hours per week. For more information, see the *Purchasing Dependent Coverage* section, page 20.

Non-Collectively Bargained Participants

The Trustees have approved Fund participation for employees of the following employers:

- the 1199 Welfare and Pension Funds
- the 1199 Training Fund, and
- the sponsoring union, the New England Heath Care Employees Union District 1199

Participation and contribution terms are set forth in Participation Agreements between those employers and the Fund.

Same-sex Couples Coverage

The Fund offers dependent coverage to the non-participant partner in a same-sex relationship, upon submission of required documentation. The required documentation varies depending on whether the same-sex couple resides in a state that authorizes either Civil Unions or Same-sex Marriages. In all cases the employee/Fund participant must be eligible for Fund dependent coverage in order for the same-sex partner to be an eligible dependent.

Required Documentation

A. Civil Union States (e.g., Connecticut or Vermont)

If you and your same-sex partner reside in a state that authorizes same-sex Civil Unions the required documentation is:

- a Civil Union Certificate, and
- Fund eligibility for dependent coverage

B. Same-sex Marriage States (e.g., Massachusetts)

If you and your same-sex partner reside in a state that authorizes Same-sex marriages, the required documentation is:

- a Marriage Certificate, and
- Fund eligibility for dependent coverage

C. States That Do Not Authorize Either Civil Unions or Same-sex Marriages

If you and your same-sex partner reside in a state that does not authorize either Civil Unions or Same-sex marriages, the eligibility criteria and required documentation are:

- you and your domestic partner are in a committed same-sex relationship that is similar to marriage
- you and your domestic partner have been each other's sole domestic partner in a relationship that has been in existence for at least 12 consecutive months
- you and your domestic partner are both age 18 or older and are mentally competent to consent to a contract
- you and your domestic partner are responsible for each other's common welfare and are jointly responsible for basic living expenses
- you and your domestic partner have shared a common residence for at least the prior 12 consecutive months and intend to do so indefinitely

- you and your domestic partner intend for your relationship to be permanent
- neither you nor your domestic partner is married or related by blood in a manner that would bar marriage in your state of residency
- you have submitted a Declaration of Domestic Partnership and other required documents, which have been accepted by the Fund
- Fund eligibility for dependent coverage

Scope of Benefits for Same-sex Couples

An eligible dependent partner in a same-sex relationship is eligible for the same Fund benefits available to an eligible dependent spouse in a heterosexual marriage **with one exception**: the dependent partner is **not** eligible for COBRA continuation coverage from the Fund.

COBRA and Same-sex Couples

COBRA — the Consolidated Omnibus Budget Reconciliation Act of 1985 — is a federal law that requires the Fund to offer continuation of coverage when certain qualifying events cause an employee, the employee's spouse and eligible dependent child(ren) to lose health care coverage.

However, a same-sex partner/spouse does not qualify as the employee's spouse under COBRA because another federal law, the Defense of Marriage Act of 1996, specifies that a spouse includes only a person of the opposite sex who is the husband or wife of the covered employee.

When a covered employee and her/his same-sex dependent partner lose Fund coverage or eligibility for certain Fund benefits, only the employee can elect COBRA coverage. The same-sex dependent partner has no COBRA rights.

Dependent Children of Same-sex Couples

The Fund's definition of "Dependent Child" (see the *Your Minor Children* section, below) applies to all Fund participants, regardless of whether the participant is married, unmarried or in a same-sex relationship.

Civil Unions and Same-sex Partnerships — Tax Issues

If you are a partner in a Civil Union or Same-sex Domestic Partnership, you must pay federal income tax on the value of your dependent's health insurance benefits, unless your partner meets the Internal Revenue Code definition of "dependent." If your same-sex domestic partner is not your IRS-qualified dependent, the Fund's cost of coverage will be considered taxable income to you and will be subject to federal, state and FICA taxes. The Fund urges you to consult a tax advisor to determine whether you can claim your same-sex domestic partner and any eligible children as dependents for tax purposes and, if you are a partner in a Civil Union, to determine whether you are liable to pay state income tax on the value of your partner's health benefits.

Your Minor Children

For purposes of Fund coverage a dependent child must be:

- the child of an eligible employee — you — and you are:
  - employed by a contributing employer, and
  - eligible for dependent coverage, based on your average hours worked
- under the age of 19 years, unmarried, dependent on you for her/his full support and is living permanently with you, or an appropriate court issues a Qualified Medical Child Support Order that provides otherwise (see the *Special Situations* section, page 111).

In addition, you must either:

- be the child's biological parent with an established legal obligation to support the child, or
- have legally adopted the child, or have begun adoption proceedings with an established legal obligation to support the child

Dependent children covered by the Fund prior to January 1, 2006, remain eligible after that date, subject to the Fund's other eligibility provisions.

Your Stepchildren

Stepchildren are not covered by the Fund as of January 1, 2006, and are not eligible for Fund coverage unless:

- you have legally adopted the child or are actively pursuing the adoption process, and
- you are eligible for dependent coverage

Stepchildren covered by the Fund prior to January 1, 2006, remain eligible after that date, subject to the Fund's other eligibility provisions.

Your Foster Children and Grandchildren

Foster children and grandchildren **are not** eligible for Fund coverage as of January 1, 2006. Foster children and grandchildren covered by the Fund prior to January 1, 2006, remain eligible after that date, subject to the Fund's other eligibility provisions. Minor children for whom you are guardian and who were not covered by the Fund prior to January 1, 2006, are not eligible for Fund coverage.

When Your Eligible Child Reaches Age 19

Your dependent child, between the age of 19 and the day she/he turns 23, continues Fund eligibility as long as:

- you remain eligible for dependent coverage, based on your average hours worked, **and**
- the child meets **all** of the following conditions:
  - is unmarried
  - is primarily dependent upon you for financial support
  - is attending high school or college on a full-time basis
  - has filed a Full-time Student Verification letter with the Fund Office upon turning age 19 and files updated letters twice a year until the child turns age 23 — see the *Special Dependent Coverage Rules for 19- to 22-year-old Students* section, page 121

Children with Disabilities

If your dependent child has a physical or mental disability and qualifies as your dependent under the rules of the Fund, the child's coverage may continue after age 19 if **all** of the following conditions are met:

- your child is not married and is incapable of supporting herself/himself
- your child resides in your household

You must provide the Fund Office with written proof of the child's disability within 31 days after she/he reaches age 19 — you will also be required periodically to provide proof of the child's continued disability.

When Your Coverage Begins

If You Are a New Employee In an Existing Bargaining Unit

You can start receiving benefits from the Fund after:

- you are hired by a contributing employer already participating in the Fund, **and**
- you have completed the probationary period specified in your Union contract — in most cases, 60 days, **and**
- you have enrolled in the Fund, **and**
- your employer has made a monthly payment of contributions to the Fund based on your covered employment.

Once all of these eligibility requirements have been met, your eligibility for coverage may be effective as early as the first day of the month following completion of your probationary period, depending on the terms of your Union contract. At the latest, you will be eligible for benefits on the first day of the month after your employer has submitted the initial payment for your benefits.

If you are an employee whose employer has recently become a contributing Fund employer, your coverage begins after you have enrolled in the Fund **and** your employer starts making contributions on your behalf as specified in the Union contract.

If You Have Dependent Coverage

Coverage for your eligible dependents starts at the same time your coverage begins if:

- you are in Wage Class I or Wage Class II
  and
- you average at least 32 hours of work per week or, in some cases, were a Fund participant prior to January 1, 1992

For more information, see *How Your Benefit Level Is Determined* section, page 17.

If You Are Employed by More than One Contributing Employer

If you are employed by more than one contributing employer, you are not entitled to multiple coverage by the Fund. However, if both you and your spouse are employed by contributing employers, the Fund will coordinate your benefits under the coordination of benefits rules. For more information, see the *Coordination of Benefits* section, page 111.

If Your Employer Fails to Make Required Contributions

If your employer fails to make required contributions on a timely basis on your behalf, your eligibility under the Fund ends on the **last day of the month** in which required contributions are not received.

Example

Employer A's last contribution is received, as due, in July 2007, which provides benefit coverage for August 2007.

If Employer A fails to make the required August 2007 contribution payment by August 31, 2007 — payment is considered delinquent if it is not received by the Fund by the last business day of the month — the last day Employer A's employees will be eligible for benefits is August 31, 2007.

In this case, you remain ineligible until your employer becomes current with the Fund or enters into a repayment schedule that is acceptable to the Fund.

HOW YOUR BENEFIT LEVEL IS DETERMINED

Your wage class determines the level of benefits you and your eligible dependents can receive from the Fund. Your average weekly hours worked determines if you are eligible for dependent coverage.

Wage class is based on the wages you earn compared with the minimum full-time wage specified in the Union contract with your employer.

There are three wage classes — Wage Class I, II and III.

YOU ARE IN...	WAGE CLASS I	WAGE CLASS II	WAGE CLASS III
If you earn...	...at least the lowest minimum full-time weekly wage stated in the Union contract with your employer.	...at least 60% but less than 100% of the lowest minimum full-time weekly wage stated in the Union contract with your employer.	...less than 60% of the lowest minimum full-time weekly wage and your employer is required to make contributions on your behalf.

New Hires

For new hires, your initial eligibility for coverage may be effective as early as the first day of the month following completion of your probationary period, depending on the terms of your Union contract. At the latest, you will be eligible for benefits on the first day of the month after your employer has submitted the initial payment for your benefits.

Your initial wage class level is the same as that earned in the first reported payroll period.

One-time Initial Rule

For first-time participants in the Fund, if your second reported payroll month is at a higher wage class level than the first, then your benefit level automatically goes to the higher level at the second month of eligibility.

Benefit Level and Wage Class

Your wage class and average weekly hours worked determine the level of benefits you and your eligible dependents receive from the Fund.

Your Coverage

YOU ARE IN:	BECAUSE YOU EARN...	YOUR BENEFIT LEVEL IS:
Wage Class I	...at least the lowest minimum full-time weekly wage stated in the Union contract with your employer...	You are eligible for the following benefits: • comprehensive health care • prescription drugs • dental care • vision • life insurance • accidental death and dismemberment, and • short-term disability
Wage Class II	...at least 60% but less than 100% of the lowest minimum full-time weekly wage stated in the Union contract with your employer...	You are eligible for the following benefits: • comprehensive health care • vision • life insurance • accidental death and dismemberment, and • short-term disability
Wage Class III	...less than 60% of the lowest minimum full-time weekly wage and worked the minimum number of hours stated in the Union contract with your employer.	You are eligible for the following benefits: • inpatient coverage for hospitalization • inpatient or outpatient surgery and related costs • emergency room treatment services • inpatient and outpatient behavioral health treatment • vision • life insurance • accidental death and dismemberment, and • short-term disability

Your Dependents' Coverage

YOU ARE IN:	IF YOU AVERAGE AT LEAST:	YOUR ELIGIBLE DEPENDENTS' BENEFIT LEVEL IS:
Wage Class I	**32 hours of work per week**	Your dependents are eligible for the following benefits: • comprehensive health care • prescription drugs • dental care, and • vision
Wage Class II	**32 hours of work per week**	Your dependents are eligible for the following benefits: • comprehensive health care, and • vision
Wage Class III		Your dependents are **not** eligible for benefits.

How Your Benefit Level Changes

If your reported wages change, your benefit level can change.

Each month the Fund looks back at the prior three months to see what wage class you earned. This "look-back" determines the benefit level you will be eligible for in the fifth (next) month.

Keeping Your Current Benefit Level

If you earn the same or a higher wage class **two out of three** months in the look-back period, you will keep your current benefit level in the fifth month. If the higher Wage Class months are consecutive, see *Moving to a Higher Benefit Level* below.

Moving to a Higher Benefit Level

If your reported earnings increase, you may move to a higher wage class. If you earn a higher wage class for **two consecutive months,** you will be eligible for a higher benefit level.

Dropping to a Lower Benefit Level

If your reported earnings are reduced, you may move to a lower wage class. If you have earned a lower wage class for **three consecutive months**, you will drop to a lower benefit level.

Reinstate Rule

If you have been on an unpaid authorized leave with a participating employer and eligibility lapses, when you return to work you will be reinstated with benefits at the benefit level you had when you began the leave. **To qualify for reinstatement you must work enough hours upon your return to require your employer to contribute to the Fund on your behalf.**

Dependent Coverage

! Important Term

In general, you must work an average of 32 hours per week to be eligible for **dependent coverage**, except if:

- you became a participant in the Fund **before** January 1, 1992, and you have continuously worked for that same employer, in which case you must work an average of 24 hours per week to have dependent coverage, or
- you have just been hired and you are a new participant in the Fund, working less than 32 hours per week, in which case you may be eligible for a one-time option to purchase dependent coverage — contact the Fund Office for details.

Highlights

In general, you must work an average of 32 hours per week to be eligible for dependent coverage.

Purchasing Dependent Coverage

If you are a new Fund participant and you don't work enough hours to earn dependent coverage (i.e., average 32 hours per week), you have a one-time option to purchase dependent coverage from the Fund. You must exercise this option within the first three months of your initial eligibility. If this option is timely exercised, your dependent coverage is identical to dependent coverage for employees regularly working 32 or more hours per week. Contact the Fund Office for the cost of coverage.

How Dependent Coverage Is Determined

Your initial eligibility for dependent coverage is determined when you first become eligible for benefits and your continued eligibility is based on your average hours worked per week.

The same three-month look-back rule that the Fund uses to determine your benefit level is applied to your hours worked to determine your eligibility for dependent coverage. If during the applicable look-back period you average 32 or more hours per week, you are eligible for dependent coverage in the coming month.

Your Benefits by Wage Class

Wage Class I

In Wage Class I, you and your eligible dependents receive the most complete set of benefits, including comprehensive health care benefits, prescription drugs, dental and vision care benefits. You are also eligible for life insurance and accidental death and dismemberment (AD&D) insurance benefits plus short-term disability insurance benefits. You are also eligible for scholarship benefits for your dependent children. In general, your dependents are eligible for coverage if you average at least 32 hours of work per week.

Wage Class II

If you are in Wage Class II, your coverage includes most of the benefits provided to Wage Class I participants. In general, your dependents are eligible for coverage if you average at least 32 hours of work per week.

Benefits NOT Covered for Wage Class II

If you are in Wage Class II, the following benefits are **not** available to you, your spouse or your dependents:

- prescription drug benefit
- dental care benefit
- scholarship benefit

Life Insurance and AD&D for Wage Class II

The Life Insurance and AD&D schedule of benefits for Wage Class II is different than for Wage Class I. Please refer to the Life Insurance schedule (page 83) and the AD&D schedule (page 89) for more information.

Wage Class III

If you are in Wage Class III, your coverage includes **some, but not all**, of the benefits provided to Wage Class I and Wage Class II participants. Further, coverage is available only to you, the Fund participant. Your spouse or dependent children are **not** eligible for any benefits.

Benefits NOT Covered for Wage Class III

If you are in Wage Class III, the following benefits are **not** available:

- medical services benefits — such as physician office visits, labs or other items listed under Medical Services for Wage Class I
- prescription drug benefit
- dental care benefit
- scholarship benefit

Maternity Benefit Limitations

Maternity benefits are provided only to you, the participant — dependents, including the newborn, are **not** covered in Wage Class III. Your maternity coverage, if applicable, is limited to inpatient hospital and surgical services. Physician visits and services, as well as lab and other diagnostic tests, are **not** covered in Wage Class III.

Life Insurance and AD&D for Wage Class III

The Life Insurance and AD&D schedule of benefits for Wage Class III is different than for Wage Class II or Wage Class I. Please refer to the Life Insurance schedule (page 83) and the AD&D schedule (page 89) for more information.

Enrolling In the Fund

To enroll in the Fund, you must get an Enrollment Form from your Union organizer, your employer or by calling the Fund Office. Complete all sections of the form and be sure to:

- ✔ complete the beneficiary section
- ✔ sign and date the form
- ✔ **return the completed Enrollment Form, and any required documentation, to the Fund Office**

When sending required documentation to the Fund, **do not** send originals. Send only copies of all required documents because they must be kept on file at the Fund Office and cannot be returned. These documents may include:

- birth certificate(s)*
- adoption paper(s)*
- a marriage certificate, if you are adding your spouse to your coverage
- if you are divorced or legally separated, your divorce or separation papers or a written statement that you have been separated for more than one year
- a Civil Union Certificate, if you are adding your civil union partner to your coverage

* **The addition of a dependent child to your coverage must be done within 31 days of the birth or adoption.** If you fail to notify the Fund about the birth or adoption or fail to provide a required marriage certificate within 31 days, payment of any eligible benefits may be delayed. For more information, see the definition of "Dependent Child" in the *Your Minor Children* section, page 13.

All information on your Enrollment Form is for Fund Office use only and will not be released to any third party, except when necessary for the administration and operation of the Fund or required by law.

USING YOUR ID CARDS

Fund Medical ID Card

If you are eligible for benefits and have enrolled in the Fund, you will receive two Fund medical identification (ID) cards. The ID cards also identify you as a participant in the Anthem BCBS PPO (Preferred Provider Organization) Network and allow you access to the BCBS National Network of participating providers. The Fund ID Card also lists the Fund's Medical Utilization Review, prescription and vision vendors and their contact information.

The Fund Protects Your Privacy

To protect your health information, the Fund does not use your Social Security Number (SSN) on your ID cards. Instead, it uses a unique identification number.

Please call the Fund Office if you have any problems with your ID card, including:

- ✔ you did not receive your card
- ✔ your card is lost or stolen
- ✔ your name is not spelled correctly
- ✔ your ID number is wrong

Highlights

Make sure that the information on your ID cards is complete and correct.

Prescription Drugs ID Card

If you are eligible for the prescription drug benefit, you will also receive two prescription drugs ID cards from the prescription drug vendor. Show your Prescription Solutions ID Card along with your prescription to any participating pharmacy to receive your medication.

If you have questions regarding your prescription drug benefit or want to save on your out-of-pocket costs by receiving your covered maintenance medications through the Mail Service Pharmacy, call the Prescription Solutions customer service phone number on your card, toll-free, at 1-800-788-7871.

Dental ID Card

If you are eligible for the dental care benefit, you will receive two Delta Dental ID Cards. During your first dental appointment, present your card to your dentist.

When going to the dentist, your eligible dependents should also present your Dental ID Card to the dentist.

For information concerning your dental benefits, call the Delta Dental customer service phone number on your card, toll-free, at 1-800-452-9310.

Using Your ID Cards

Under the terms of your Fund coverage, you have the option to use Network providers or Out-of-Network providers. Generally, Network providers save you time and money while providing you with quality service.

When you use a Network provider you do not have to file a claim form. You just show your ID card so that the Network provider knows to bill the Fund. The following are the steps you need to take for your services to be covered:

- **Medical Claims**
  Show the provider your Fund Medical ID Card. Providers will submit claims directly to Anthem BCBS. You will be billed for your share of the cost, if any.

- **Hospital Claims**
  Show the hospital your Fund Medical ID Card. Hospitals will submit claims directly to Anthem BCBS. You will be billed for your share of the cost, if any.

- **Behavioral Health Claims**
  Show the provider your Fund Medical ID Card. The provider will send claims directly to Anthem BCBS. You will be billed for your share of the cost, if any.

- **Prescription Drug Claims**
  Retail Pharmacy: Show your Prescription Solutions ID Card to a participating pharmacist with your prescription. The pharmacist will ask you for payment of the co-pay at the time the prescription is filled. The pharmacy will submit claims directly to Prescription Solutions.

  Mail Service Pharmacy: Maintenance drug prescriptions are filled by mail order for a 90-day supply of the medicine and you pay just one co-pay.

For more information on the Mail Service Pharmacy, call the Prescription Solutions customer service phone number on your Prescription Drugs ID Card, toll-free, at 1-800-788-7871 or the Fund Office.

◆ Dental Claims

Show the dentist your Delta Dental ID Card. Providers will submit claims directly to Delta Dental, the Dental Care vendor. You will be billed for your share of the cost, if any.

If you have any questions, call Delta Dental's customer service phone number on your Dental ID Card, toll-free, at 1-800-452-9310.

◆ Vision Claims

When you call for an appointment tell your optometrist that you have Davis Vision. Your optometrist will bill Davis Vision directly. You will be billed for your share of the cost, if any.

If you have any questions, call Davis Vision's customer service phone number listed on your Fund Medical ID Card, toll-free, at 1-800-999-5431.

Use and Rights of Your ID Cards

Possession of any Fund ID card does not automatically give eligibility for Fund benefits. If you are no longer eligible for benefits, you or your dependents may not use any ID card from the Fund. If you do, you will be personally responsible for all charges.

Your ID cards are for use by you and your eligible dependents only. You should not allow anyone else to use your ID cards to obtain Fund benefits. If you do, the Fund will deny payment and you will be personally responsible to the provider for the charges. If the Fund has already paid for these benefits, you will have to reimburse the Fund. The Fund may also deny benefits to you and your eligible dependents and may initiate civil or criminal actions against you until you repay the Fund.

HOW TO ACCESS SERVICES

About Pre-certification and Prior Approval

Certain health care services, such as hospitalization and inpatient or outpatient behavioral health treatment, require pre-certification with the Fund's Medical Utilization Review vendor or the Fund to ensure your coverage for those services.

Highlights

Pre-certification helps ensure that you receive cost-effective and medically necessary care.

Pre-certification — also known as authorization, certification, prior approval or prior authorization — helps ensure that you and your family receive medically necessary health care services at the appropriate level of care in a timely, effective and cost-efficient manner. Because it helps you reduce health risks and avoid unnecessary hospitalizations, pre-certification also helps you and the Fund to reduce costs.

When you or your family need services requiring pre-certification, you or your provider must call and pre-certify those services **before** receiving treatment. **Failure to pre-certify can result in penalties on claims or denial of claims, which means more out-of-pocket expenses for you.**

Hospital Stay

If you or an eligible member of your family needs to be admitted to the hospital, you or your health care provider must call the Medical Utilization Review vendor, Hines & Associates, toll-free, at 1-800-670-7718 to:

- pre-certify your hospital stay before going to the hospital for non-emergency care

- notify Hines & Associates within 48 hours of an emergency admission to the hospital.

If you are unable to call, someone may call for you. But in all cases, it is your responsibility to make sure that the pre-certification or notification call is made. If you don't call to pre-certify a non-emergency admission or to provide notification of an emergency admission to the hospital within 48 hours, you will have to pay a 20% penalty of the hospital bill, up to a maximum of $500 per admission.

If you go to the emergency room for non-emergency care there is a $25 penalty. See the definition of "Emergency, Medical" in the *Health Care Terms* section, page 148.

Behavioral Health

If you or an eligible member of your family needs inpatient or outpatient behavioral health treatment, you or your health care provider must contact the Medical Utilization Review vendor, Hines & Associates, toll-free, at 1-800-670-7718 to pre-certify:

- **all** inpatient behavioral health treatment
- outpatient behavioral health treatment **after** the first 10 visits per calendar year
- behavioral health Intensive Outpatient Program (IOP) or Partial Hospital Program (PHP) **after** the first 10 days (per calendar year)

Behavioral Health benefits (except the first 10 outpatient visits and the first 10 days of IOP and PHP) will not be paid if your care is not approved in advance by the Medical Utilization Review vendor. This is true whether the treatment is received from a Network or Out-of-Network provider.

Medical Services Requiring Prior Approval from the Fund

You or your health care provider must call the Fund Office for prior approval of the following services:

- **bariatric surgery (e.g., stomach stapling — only covered if accompanied by a diagnosis of morbid obesity and at least one secondary diagnosis)**
- **breast reduction**
- **breast prosthesis** - one external silicone breast prosthesis per side or partial prostheses (equalizers or enhancers) covered every two years, or a non-silicone breast form every six months and two post-reconstructive/ surgical bras or two post-mastectomy bras every six months if prescribed by a physician
- **Continuous Positive Airway Pressure (CPAP) machine** - including a specially designed humidifier for attachment to the CPAP machine
- **depth or custom-molded shoes** - up to one pair per calendar year, if prescribed by a physician
- **durable medical equipment**
- **non-emergency transportation services**
- **organ transplants**
- **sleep study**
- **speech therapy**
- **support stockings** - up to two pairs per calendar year, if prescribed by a physician
- **two or more related operations** - if needed during the same hospital stay
- **wigs** - up to two per calendar year, up to a maximum of $350 per wig, if needed due to chemotherapy or radiation therapy and prescribed by a physician

Using Network Providers

Network (Participating) Providers

Important Term

The Fund has contracted with Anthem Blue Cross Blue Shield (BCBS) to access the BCBS national network of health care providers to provide Fund participants with benefit services on a cost-effective basis. Using these **Network**, or **participating, providers** means:

- you save money — when you use Network providers you pay the lower annual deductible and co-insurance amounts, and you and the Fund get the benefit of discounted rates
- no hassle — Network providers file the claim and bill the Fund for you; you have no paperwork and no money to pay up front

Keep in mind that certain medical services require pre-certification regardless of whether or not you use Network providers. For more information see the *About Pre-certification and Prior Approval* section, page 25.

Anthem Blue Cross Blue Shield (BCBS) for Medical and Hospital Benefits

The doctors, hospitals, clinics, labs and other health care providers that the Fund contracts with through Anthem BCBS provide health care to the Fund's participants at reduced fees.

Important Term

This arrangement is called a **PPO — Preferred Provider Organization** — which allows Fund participants and their eligible dependents access to all Anthem providers in Connecticut and the national BCBS Network as Network providers. If you live, work or travel outside of Connecticut, you have the same benefits and services that you receive in Connecticut.

The Anthem BCBS Network is a comprehensive network of participating doctors and all general hospitals in Connecticut, and is the largest health care network in the United States, with more than 85% of all physicians and hospitals. You also have access to Network doctors and hospitals located in 218 countries. Call the phone number on the front of your ID card — toll-free, 1-800-810-BLUE (1-800-810-2583) — for locations.

Highlights

If your Network provider refers you to another health care provider, you need to make sure that the provider you are referred to is also a Network provider.

Make Sure You Are Referred to Another Network Provider

If your Network provider needs to refer you to another health care provider, you need to make sure that the provider you are referred to is also a Network provider. If the provider is an Out-of-Network provider, you will have to pay the higher Out-of-Network deductible and co-insurance amounts.

Directory of Network (Participating) Health Care Providers

For the name of a Connecticut or national Network health care provider, hospital or facility, call the Fund Office or:

- call the phone number on the front of your ID card — toll-free, 1-800-810-BLUE (1-800-810-2583), or
- visit the Anthem BCBS website at www.Anthem.com, enter your ZIP Code and click on "Find A Doctor"

Network Providers for Other Benefits

The Fund has also selected vendors for the following benefits:

- Prescription drugs
- Dental
- Vision

Go to the section discussing these benefits for specific information about Network providers.

Changes in Network (Participating) Providers

The networks listed in this SPD are up to date as of the publication date — January 2007. However, the Fund may discontinue using certain networks or contract with new networks at any time — you'll be notified if this occurs.

Also, keep in mind that individual providers, such as physicians, hospitals, dentists, pharmacies, etc., contract separately with the networks. Always check directly with the individual health care provider you plan to see to make sure that they participate in the Fund's selected network.

Choose One Doctor for Your Primary Health Care Needs

It is important that you choose a doctor who you are comfortable with and who you trust. Once you have chosen your doctor, visit your doctor regularly for checkups and health screenings — not just when you are sick.

Highlights

With regular visits, minor problems can be treated before they become serious illnesses.

By seeing your doctor regularly, your doctor gets to know you and your overall medical condition and can better monitor your health care needs. With regular visits, minor problems can be treated before they become serious illnesses.

If you need a referral to a specialist, ask your doctor to refer you to a specialist in the Network.

Out-of-Network (Non-participating) Providers

! Important Term

You can choose any doctor, hospital or other health care provider that you want for your family's care. But, if you choose an **Out-of-Network provider** you can be billed whatever the provider charges and you will have to pay any cost over the Fund's network-allowed charge for covered services, as well as the higher Out-of-Network deductible and co-insurance amounts.

An Out-of-Network provider may require full payment from you at the time of service or may bill you directly. If you pay the Out-of-Network provider you will have to send the itemized bill to the Fund Office for reimbursement.

Coordination of Benefits

Frequently, members of a family have health care coverage in addition to the benefits provided by the Fund and participants are **required** to notify the Fund and provide information about such coverage. When this happens, the amount of benefits payable by the Fund will take into account any coverage you or a family member has under another health plan so that the **combined benefits** provided by the Fund and the other plan will not be more than the total expenses involved.

For more information, please see *Coordination of Benefits* under the *Special Situations* section, page 111.

LIFE EVENTS AND YOUR BENEFITS

Key Life Events

Your life can change over time — you may get married, have a child, get divorced or retire. These important events in your life are called "key life events." After each key life event, described below, you will find a list of actions you need to take.

It is important that you notify the Fund of any changes in your personal situation by filling out a Change of Enrollment Form. Call the Fund Office and ask for a Change of Enrollment Form.

Highlights

Changes described below that involve your spouse or dependent child assume that they are eligible for coverage under the Fund, based on your wage class and your average weekly hours of work.

If you have any questions or need to get a copy of any of the forms listed below, you can call the Fund Office.

Adding a Dependent to Coverage

Event	Action
Change of name, address or phone number	**Submit to the Fund Office:** • a completed Change of Enrollment Form
Adding new spouse to coverage	**Submit to the Fund Office:** • a completed Change of Enrollment Form, and • a copy of your marriage certificate You may also change your beneficiary for your life and AD&D insurance coverage on the Change of Enrollment Form.
Adding new civil union partner to coverage (applicable to Connecticut residents only)	**Submit to the Fund Office:** • a completed Change of Enrollment Form, and • a copy of your Civil Union Certificate You may also change your beneficiary for your life and AD&D insurance coverage on the Change of Enrollment Form.
Adding a new same-sex domestic partner to coverage (not applicable to Connecticut or Massachusetts residents)	**Submit to the Fund Office:** • a completed Change of Enrollment Form, and • all required Fund documentation (see page 12) You may also change your beneficiary for your life and AD&D insurance coverage on the Change of Enrollment Form.
Adding a dependent child to coverage	**Submit to the Fund Office:** • a completed Change of Enrollment Form, and • all required Fund documentation (see page 13) You may also change your beneficiary for your life and AD&D insurance coverage on the Change of Enrollment Form.

Having or Adopting a Baby

EVENT	ACTION
You or your covered spouse becomes pregnant	Call or use the Anthem BCBS website www.Anthem.com to locate an obstetrician and a pediatrician who participate in the Anthem BCBS Network. See the *Contact Information* section, page 6. Review the *Maternity Care Benefits* section, page 45.
When a child is born or adopted	Notify Hines & Associates at 1-800-670-7718 of your hospital stay within 48 hours of your admission to the hospital. **Submit within 31 days to the Fund Office:** • a completed Change of Enrollment Form. Failure to notify the Fund Office within 31 days may delay payment of any benefits to you or your dependents. • a copy of the birth certificate or adoption papers and all required documentation to establish the eligibility of the child for dependent coverage (see definition of "Dependent Child" on page 13) Review the *Well Baby and Well Child Care Benefits* section, page 53. You may also change your beneficiary for your life and AD&D insurance coverage on the Change of Enrollment Form.

Divorce, Legal Separation (or separation for more than one year) or Termination (Civil Union or a same-sex domestic partnership)

EVENT	ACTION
Change of name	**Submit to the Fund Office:** • a completed Change of Enrollment Form
Remove a divorced or separated spouse or a former Civil Union or same-sex domestic partner from coverage	**Submit to the Fund Office:** • a completed Change of Enrollment Form, and • a copy of your divorce decree, separation agreement or letter stating that you have been separated more than one year or evidence of termination of a Civil Union or Same-sex marriage You may also change your beneficiary for your life and AD&D insurance coverage on the Change of Enrollment Form.

Layoff, Termination or Taking a New Job

EVENT	ACTION
Leaving covered employment	Notify the Fund Office. If you are laid off or your facility closes, see the *Continuation of Coverage* section, page 123. For information about continuation of health care coverage under COBRA, see the *When You Leave Covered Employment or Retire* section, page 129. For information about converting your life and AD&D insurance coverage to a personal policy, see the *Life Insurance Benefits* (page 83) and *Accidental Death, Dismemberment and Loss of Sight Benefits* (page 89) sections.

Retirement

EVENT	ACTION
Retiring from covered employment	Contact the Fund Office. If you first became a Fund participant **on or after** January 1, 1992, review the *When You Leave Covered Employment or Retire* section, page 129. If you first became a Fund participant **before** January 1, 1992, and you have continuously remained a participant until immediately prior to your retirement, review the *Your Retiree Benefits* section, beginning on page 97.

Death

EVENT	ACTION
In the event of your death	A family member must contact the Fund Office.
In the event of the death of a covered family member	Contact the Fund Office. You may also change your beneficiary for your life and AD&D insurance coverage on the Change of Enrollment Form.

YOU SHARE THE COST

While the Fund pays most of the cost of health care for you and your eligible spouse and dependents, you also share some of this cost including:

- **annual deductible for you and your family** — which must be met before the Fund begins to pay its share for covered services each year
- **co-insurance amounts** — which are payable until you reach the annual out-of-pocket maximum
- **co-pays** — which represent your total cost for your prescription drugs

Highlights

If you use Network providers you have a lower annual deductible and co-insurance amount and you get the benefit of discounted rates.

You Share the Cost of Medical Services

You are responsible for:	COST SHARING	
	NETWORK	OUT-OF-NETWORK
Annual Deductible	The first $250 per Individual or $500 per Family of medical cost each calendar year	The first $500 per Individual or $1,000 per Family of medical cost each calendar year
Co-insurance:		
You Pay	20% of network-allowed charges after annual deductible is met	30% plus any charges over the network-allowed charge (any charge over the network-allowed amount does not count toward the Out-of-Pocket maximum)
Fund Pays	80% of network-allowed charges after annual deductible is met	70% of network allowed charges
Annual Out-of-Pocket Maximum	$1,250 per individual or combined total per family	
Fund's Annual Maximum Benefit	$200,000 per person	
Fund's Lifetime Maximum Benefit	$1,000,000 per person	

Annual Deductible

Important Term

All allowed claims for benefits from eligible family members count toward meeting the **annual deductible**. Individual family members do not pay more than $250 in deductible claims cost and the whole family does not pay more than $500 — if they use Network providers.

Example

A family of four, all covered by the Fund, uses only Network providers, so their maximum total annual deductible is $500.

The mother has paid the first $250 toward claims. Therefore, she has met her individual deductible.

This means that the three other family members' claims count toward meeting the remaining $250 of the $500 annual family deductible.

Co-insurance

Important Term

Once the annual deductible has been met, you and the Fund will share the cost of covered services. Your share of the cost is called your **co-insurance**. The cost of your expenses depends on whether you use Network or Out-of-Network providers.

If you use:

- **Network providers:** the Fund pays 80% of the network-allowed charge, and you pay 20%.

Example

A Network provider charges $120.
The network-allowed charge is $100.

The Fund will pay $80 (80% of $100). You pay a co-insurance of $20.

Your $20 co-insurance will count toward your Out-of-Pocket maximum.

- **Out-of-Network providers:** the Fund pays 70% of the network-allowed charge and you pay 30% plus any charges over the network-allowed charge.

Example

An Out-of-Network provider charges $120.
The network-allowed charge is $100.

The Fund will pay $70 (70% of $100). You pay a co-insurance of $30 plus the **additional** $20 that is over the network-allowed charge. You pay a total of $50, including co-insurance and amounts that exceed the network-allowed charge.

Only the $30 co-insurance will count toward your Out-of-Pocket maximum.

Annual Out-of-Pocket Maximum

Important Term

The $1,250 **Annual Out-of-Pocket maximum** amount is the most that you or your family will have to pay for medical benefits in a calendar year, subject to the Fund's annual and lifetime maximums — if you use Network providers.

Highlights

When your annual deductible and your co-insurance payments total $1,250, the Fund pays 100% of remaining expenses, subject to the annual and lifetime maximums — if you use Network providers.

If your annual deductible and your co-insurance payments together reach $1,250 — for either yourself or your family — you don't have to pay any more out-of-pocket expenses if you use Network providers. The Fund pays 100% of the charges, up to the Annual and Lifetime Maximum Benefits.

Co-pays and deductibles for prescription drugs, dental and vision care and penalty fees do not count toward either the medical claims annual deductible amount or the annual Out-of-Pocket maximum. Even if you reach the annual Out-of-Pocket maximum, you are still responsible for any prescription drug, dental or vision co-pays.

Annual Maximum Benefit

Important Term

The maximum amount of medical care benefits that the Fund will pay for any individual in a calendar year is $200,000 — your **Annual Maximum Benefit**.

Lifetime Maximum Benefit

Important Term

The maximum amount of medical care benefits that the Fund will pay for an individual during her/his lifetime is $1,000,000.

Your **lifetime maximum benefit** does not include any Fund payments for prescription drug, dental, vision, short-term disability, life insurance, accidental death and dismemberment (AD&D) or scholarship benefits.

Co-pay

Important Term

A **co-pay** is a fixed amount of money you pay for prescription drugs. The Prescription Drug benefit has a $10 co-pay for generic drugs and a $30 co-pay for brand name drugs.

About Claims

When you see a Network provider, show your Fund ID card so the network provider knows to submit the bill to Anthem BCBS to bill the Fund. The provider will complete and submit any required paperwork.

However, if you are treated by an Out-of-Network provider, the provider may require full payment or may bill either you or the Fund directly. If you are billed and pay the Out-of-Network provider, you have to send the itemized bill to the Fund Office for reimbursement.

See the *How Claims Are Filed* section, page 105, for information about claims, the claims process and timelines, and your appeal rights.

YOUR ROLE IN CONTROLLING HEALTH CARE COSTS

Health care costs continue to increase every year. You can help control both your own and the Fund's health care costs by:

- using Network providers whenever possible
- selecting one primary care physician to manage all your and your family's care
- using hospital emergency rooms only for real medical emergencies
- pre-certifying any hospital stay
- pre-certifying:
  - all inpatient behavioral health treatment
  - outpatient behavioral health treatment **after** the first 10 visits, per calendar year
  - behavioral health Intensive Outpatient Program (IOP) or Partial Hospital Program (PHP) **after** the first 10 days per calendar year
- providing notification within 48 hours of an emergency admission to the hospital
- using the mail pharmacy for medications you expect to take for six months or more
- reviewing the charges on your medical bills and EOB (explanation of benefits) and notifying the Fund Office of any errors or mistakes you find

If you follow these steps you will be reducing your medical costs as well as helping the Fund stay financially secure and able to continue to provide you and your family with the level of benefits you want and need.

PC

Alert!
Pre-certification is required.

N

Alert!
Notification is required.

HOSPITAL CARE, INPATIENT AND OUTPATIENT SURGERY BENEFITS

		YOU	SPOUSE	CHILDREN
Wage Class I	< 32	Y		
	≥ 32	Y	S	C
Wage Class II	< 32	Y		
	≥ 32	Y	S	C
Wage Class III		Y		

Pre-certification/Notification

All inpatient hospital stays — including hospice care — for you or any covered dependents require pre-certification. Pre-certification allows the Fund to help you and your health care provider ensure that you are receiving appropriate care and that your hospitalization does not last longer than medically necessary.

You, a family member or your doctor must call the Medical Utilization Review vendor, Hines & Associates, toll-free, at 1-800-670-7718 to pre-certify **before** you or a covered dependent is admitted to the hospital. This phone number can also be found on your Fund ID Card.

In the case of an emergency admission to the hospital, you, a family member or your doctor are required to notify the Medical Utilization Review vendor, Hines & Associates, toll-free, at 1-800-670-7718 to provide notice **within 48 hours** of the admission to the hospital or hospitalization for delivery of a newborn, when you or your spouse are admitted to a hospital to give birth. This phone number can also be found on your Fund ID Card.

Failure to Pre-certify or Provide Required Notification

You will have to pay a penalty of 20% of hospital charges, up to a maximum of $500 per admission, if you do not call Hines & Associates to:

- **pre-certify** before being admitted to the hospital, or
- **provide notice** within 48 hours of an emergency admission to the hospital or hospitalization for delivery of a newborn

The $500 per admission penalty does not count toward the annual out-of-pocket maximum or satisfaction of your deductible.

Your Coverage

Your Inpatient Hospitalization Coverage

If you need to be admitted to the hospital the following services are covered by the Fund:

- ✔ semi-private room and board
- ✔ medically necessary services and supplies furnished by the hospital
- ✔ x-ray and other diagnostic imaging services
- ✔ laboratory services
- ✔ prescription drugs and medicines
- ✔ medical supplies and dressings
- ✔ anesthetics and hospital charges for giving anesthetics
- ✔ inpatient physical rehabilitation
- ✔ inpatient hospice care

Inpatient Surgery

You are covered for surgery when performed by a licensed physician or surgeon in a licensed hospital.

Inpatient surgery requires pre-certification. This means that you, a family member or your doctor must call the Medical Utilization Review vendor, Hines & Associates, toll-free, at 1-800-670-7718 **before** you or any covered dependent is admitted to the hospital for inpatient surgery. This phone number can also be found on your Fund ID Card.

If your health care provider has said that you need two or more related operations during the same hospital stay, there may be limitations on your coverage. For more information, call the Fund Office.

Short-term Rehabilitation Services

The Fund covers short-term rehabilitation services and nursing home stays only when used instead of hospitalization and subject to pre-certification approval by the Medical Utilization Review vendor, Hines & Associates, toll-free, at 1-800-670-7718, as listed on your Medical ID card.

Outpatient (Ambulatory) Surgery

You do **not** have to pre-certify your surgery if it is going to be performed in:

- the outpatient department of a hospital
- a free-standing surgical center, or
- a doctor's office

Coverage for outpatient surgical care includes:

- ✔ physician or surgeon charges
- ✔ x-ray and other diagnostic imaging services
- ✔ laboratory services
- ✔ prescription drugs and medicines
- ✔ medical supplies and dressings, and
- ✔ anesthetics and charges for administering anesthetics

Outpatient Cardiac Rehabilitation

Outpatient cardiac rehabilitation is covered for:

1. patients who begin the program within 12 months of an acute myocardial infarction (i.e., heart attack)
2. patients who have had coronary artery bypass (CABG) surgery, and
3. patients with chronic stable angina

Organ Transplants

The Fund covers organ transplants only if they are pre-certified. Such transplants are subject to the existing annual and lifetime maximum benefit limits.

You, a family member or your doctor must call the Medical Utilization Review vendor, Hines & Associates, toll-free, at 1-800-670-7718 **before** you or any covered dependent undergoes an organ transplant. This phone number can also be found on your Fund ID Card.

Any organ transplants considered to be experimental are not covered by the Fund.

Emergency Room Services

A medical emergency is the sudden and unexpected onset of an illness or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. You and your family should go to the emergency room only when you have a medical emergency that can't be treated at a physician's office.

If you are hospitalized for a medical emergency, you, a family member or your doctor must notify the Medical Utilization Review vendor, Hines & Associates, toll-free, at 1-800-670-7718 **within 48 hours** of the emergency admission to the hospital. This phone number can also be found on your Fund ID Card.

If you do not call Hines & Associates within 48 hours of an emergency admission to the hospital you will have to pay a penalty of 20% of hospital charges, up to a maximum of $500.

Highlights

There is a $25 penalty if you visit the emergency room for non-emergency treatment.

Non-emergency Care Penalty

If you use the emergency room for non-emergency treatment, there will be a $25 penalty fee.

Transportation Services

The Fund also covers emergency and certain non-emergency transportation associated with your health care. Your coverage includes:

- **emergency** transportation and services to the closest hospital where you can be treated for the onset of a sudden and serious illness or injury, and
- approved **non-emergency** health care transportation — for example, for transportation between medical facilities.

To get approval for non-emergency transportation services, call the Fund Office. Failure to get Fund approval may result in a denial of benefits.

Finding a Network Hospital

The Anthem BCBS Network includes all general hospitals in Connecticut and access to 85% of all hospitals nationwide. For a list of Network hospitals, call the Fund Office or:

- call Anthem Blue Cross Blue Shield (BCBS), toll-free, at 1-800-810-BLUE (1-800-810-2583), or
- visit the Anthem BCBS website at www.Anthem.com

YOUR RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER ACT OF 1998

The Fund complies with federal law related to mastectomies. If you or an eligible dependent has a mastectomy and then chooses to have breast reconstruction, the Fund, in consultation with the patient and doctor, will provide coverage based upon the network-allowed charges for:

- ✔ all stages of reconstruction of the breast on which the mastectomy was performed
- ✔ surgery and reconstruction of the other breast to produce a symmetrical appearance
- ✔ prostheses, and
- ✔ physical complications of the mastectomy — including lymphedemas

These benefits will be subject to the normal co-insurance or deductible amounts, if any apply.

MATERNITY CARE BENEFITS

		YOU	SPOUSE	CHILDREN
Wage Class I	< 32	Y		
	≥ 32	Y	S	
Wage Class II	< 32	Y		
	≥ 32	Y	S	
Wage Class III		Y		

Covered maternity care benefits for an eligible mother/spouse and newborn include:

- ✔ all prenatal and postnatal visits and delivery charges
- ✔ hospital benefits for the mother/spouse and newborn if you are eligible for dependent coverage, based on your wage class and average hours worked per week
- ✔ short-term disability benefits for you if you are the mother and a Fund participant

Eligibility for these benefits is dependent on you being eligible for dependent coverage and being the biological parent with a legal obligation to support the newborn, or the newborn is your legally adopted child.

Having a Healthy Baby

With regular prenatal care, complications that occur during pregnancy can be found early and treated to reduce the risk of harming you and your baby. Prenatal care includes:

- ✔ visits to the doctor, and
- ✔ the medical care received by the mother during her pregnancy

Notification

In the case of childbirth, you do not have to pre-certify your hospital admission.

However, you must notify the Medical Utilization Review vendor, Hines & Associates, toll-free, at 1-800-670-7718 **within 48 hours** of when you or your spouse is admitted to the hospital to give birth. You will be assisted in obtaining appropriate medical treatment. This phone number can also be found on your Fund ID card.

What's Not Covered

⊘ Your dependent child's pregnancy and related expenses are **not** covered.

YOUR RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Fund complies with federal law:

- ◆ A mother and her newborn child are allowed to stay in the hospital for at least 48 hours after delivery — or at least 96 hours after a cesarean section.
- ◆ A provider is not required to obtain authorization for prescribing these minimum lengths of stay.
- ◆ However, the mother and her provider still may decide that the mother and newborn should be discharged before 48 (or 96) hours.

MEDICAL BENEFITS

		YOU	SPOUSE	CHILDREN
Wage Class I	< 32	Y		
	≥ 32	Y	S	C
Wage Class II	< 32	Y		
	≥ 32	Y	S	C
Wage Class III				

Covered Medical Services

Covered medical services, which cover treatment in a doctor's office, clinic or hospital, include:

- ✔ **office visits**
- ✔ **routine physical exams -** one exam every other calendar year for adults
- ✔ **x-rays and other diagnostic imaging services and routine laboratory tests**
- ✔ **outpatient chemotherapy, radiation therapy and hemodialysis**
- ✔ **medical supplies and equipment -** with some exceptions
- ✔ **gynecological exams -** one exam per calendar year
- ✔ **acupuncture treatment -** up to 30 visits per calendar year, if performed by a licensed M.D. or D.O.
- ✔ **allergy treatment -** no maximum number of visits, if medically necessary
- ✔ **chiropractic services -** up to 30 visits per calendar year
- ✔ **dermatology treatment -** up to 20 visits per calendar year
- ✔ **occupational therapy and speech therapy -** up to 30 visits per calendar year, **combined** for both therapies
- ✔ **physical therapy -** up to 30 visits per calendar year
- ✔ **podiatry care -** up to 15 visits per calendar year, for routine care (if patient is diabetic or on prescription blood thinners)

Adult Immunizations

The Fund covers specific vaccines in specific situations:

Females Ages 11 to 26

The vaccine Gardasil is covered for females, ages 11 to 26.

Up to Age 65

You and your eligible dependents are covered for the following, only if the patient has a history of one of the following conditions: chronic lung disease, cancer, spleen removed, cystic fibrosis, sickle cell anemia, diabetes, heart condition, asthma, allergies and acute bronchitis:

- ✔ Influenza vaccine, as prescribed
- ✔ Pneumonia vaccines, as prescribed

The following vaccines are covered for adults at risk if recommended by the patient's doctor:

- ✔ Hepatitis B vaccine
- ✔ Measles-Mumps-Rubella (MMR) vaccine
- ✔ Varicella (chicken pox) vaccine
- ✔ Tentanus-Dyphtheria vaccine, once every 10 years

Age 65 and Over

You and your eligible spouse are covered for the following:

- ✔ Influenza vaccine, once each year
- ✔ Pneumonia vaccine, once every five years

The Fund does not cover vaccines needed for traveling overseas.

HEARING AID BENEFITS

		YOU	SPOUSE	CHILDREN
Wage Class I	< 32	Y		
	≥ 32	Y	S	C
Wage Class II	< 32			
	≥ 32			
Wage Class III				

Hearing Aids

	NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
HEARING EXAMS (one exam every 24 months)	You pay: 20% of network-allowed charges	You pay: 30% of network-allowed charges, plus any charges over the network-allowed charges
PERMANENT HEARING AID (one appliance per ear every 24 months)	Maximum Benefit $200 per appliance per ear	Maximum Benefit $200 per appliance per ear

What's Covered

The Fund provides coverage for the cost of a permanent hearing aid to a maximum benefit amount of $200 for each appliance for each ear during a 24-month period. This period will begin on the date a charge is first incurred.

What's Not Covered

The following is not covered by the Fund:

- the cost of any hearing aid or device not prescribed by your doctor
- the cost of replacement batteries or cords

Where Do I Find a Network Provider?

For a list of Network providers, you can call the Fund Office or:

- call Anthem Blue Cross Blue Shield (BCBS), toll-free, at 1-800-810-BLUE (1-800-810-2583), or
- visit the Anthem BCBS website at www.Anthem.com

REPRODUCTIVE BENEFITS

Contraceptives

The Fund covers birth control pills and other prescribed contraceptives. Prescribed birth control pills are covered by the Fund Prescription Drug plan. Medical contraceptive devices prescribed by a doctor, such as an IUD or diaphragm, are covered under the medical benefit. For more information, please see the *Prescription Drugs* section, page 61.

		YOU	SPOUSE	CHILDREN
Wage	< 32	Y		
Class I	≥ 32	Y	S	C
Wage	< 32	Y		
Class II	≥ 32	Y	S	C
Wage				
Class III				

Infertility Services

Only infertility services related to the **diagnosis** of infertility are covered. Any **treatments** for infertility, for example, artificial insemination or in vitro fertilization, are not covered.

		YOU	SPOUSE	CHILDREN
Wage	< 32	Y		
Class I	≥ 32	Y	S	
Wage	< 32	Y		
Class II	≥ 32	Y	S	
Wage				
Class III				

Sterilizations / Reversals

The Fund covers vasectomies and tubal ligations. The Fund does not cover reversals of sterilization.

		YOU	SPOUSE	CHILDREN
Wage	< 32	Y		
Class I	≥ 32	Y	S	
Wage	< 32	Y		
Class II	≥ 32	Y	S	
Wage		Y		
Class III				

Where Do I Find a Network Provider?

For a list of Network providers, you can call the Fund Office or:

- call Anthem Blue Cross Blue Shield (BCBS), toll-free, at 1-800-810-BLUE (1-800-810-2583), or
- visit the Anthem BCBS website at www.Anthem.com

99

WELL BABY AND WELL CHILD CARE BENEFITS

		YOU	SPOUSE	CHILDREN
Wage Class I	< 32			
	≥ 32			C
Wage Class II	< 32			
	≥ 32			C
Wage Class III				

Well Baby Care

Well baby care covers routine care for eligible newborn dependent children through age 24 months, including:

- ✔ one doctor visit every other month to age six months
- ✔ one doctor visit every three months from age six months to 24 months, and
- ✔ routine immunizations and lab charges

Well Child Care

From age two to age 19, your eligible dependent child is covered for one routine physical exam each year and routine immunizations and lab charges.

The vaccine Gardasil is covered for females, ages 11 to 26.

Please note that school and camp screenings are **not** covered.

Where Do I Find a Network Provider?

For a list of Network providers, you can call the Fund Office or:

- ◆ call Anthem Blue Cross Blue Shield (BCBS), toll-free, at 1-800-810-BLUE (1-800-810-2583), or
- ◆ visit the Anthem BCBS website at www.Anthem.com

99

BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE ABUSE) BENEFITS

		YOU	SPOUSE	CHILDREN
Wage Class I	< 32	Y		
	≥ 32	Y	S	C
Wage Class II	< 32	Y		
	≥ 32	Y	S	C
Wage Class III		Y		

Pre-certification

You are required to contact the Medical Utilization Review vendor, Hines & Associates, toll-free, at 1-800-670-7718 to pre-certify:

- **all** inpatient behavioral health treatment
- outpatient behavioral health treatment **after** the first 10 visits per calendar year
- behavioral health Intensive Outpatient Program (IOP) or Partial Hospital Program (PHP) **after** the first 10 days per calendar year

Failure to Pre-certify

Benefits will not be paid if your care is not pre-approved by the Medical Utilization Review vendor. This is true whether the treatment is received from a Network or Out-of-Network provider.

Inpatient and Partial Hospitalization

When you need to go to the hospital or other approved facility for treatment of a diagnosed behavioral health condition, you are covered for up to:

- ✔ 30 full inpatient days per calendar year, or
- ✔ 60 partial inpatient days, or
- ✔ a combination of full inpatient and partial inpatient days that does not exceed 30 full inpatient days per calendar year.

You are not covered for the following:

- ⊘ room and board for Intensive Outpatient Program

Outpatient Coverage

When you need to visit a behavioral health care provider, you are covered for:

- 35 outpatient visits per calendar year

Where Do I Find a Network Provider?

For a list of Network providers, call the Fund Office or:

- call Anthem Blue Cross Blue Shield (BCBS), toll-free, at 1-800-810-BLUE (1-800-810-2583), or
- visit the Anthem BCBS website at www.Anthem.com

HOME CARE BENEFITS

		YOU	SPOUSE	CHILDREN
Wage Class I	< 32	Y		
	≥ 32	Y	S	C
Wage Class II	< 32	Y		
	≥ 32	Y	S	C
Wage Class III				

In some circumstances, the Fund covers home nursing, home hospice, health transportation, medical supplies and durable medical equipment.

There are some situations, described below, when you must call the Fund Office or the Medical Utilization Review vendor, Hines & Associates, listed on your medical ID card for approval **before** you use or purchase certain services, supplies or equipment.

Home Nursing Care

Home nursing care is covered for you and your eligible dependents only if you are home-bound — you are unable to leave your home except to visit your health care providers and the services are:

- medically necessary
- used instead of hospital care, and
- pre-certified by the Medical Utilization Review vendor, Hines & Associates. Call Hines & Associates toll-free, at 1-800-670-7718. This number is also listed on your Medical ID Card.

If you need and qualify for nursing care at home, the Fund benefits are:

- skilled nursing care, and
- home health aides

Home nursing care includes services prescribed by a doctor and must be provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.). An R.N. or L.P.N. provides home nursing care services such as:

- monitoring of vital signs
- administration of medication, and
- various therapies

Services rendered by relatives who are related by blood or marriage or by someone who resides in your home or the home of a dependent are **not** covered.

Home nursing care does **not** include custodial care. Custodial care helps the individual with the activities of daily living that do not require professional medical personnel. Such activities include:

- homemaking
- preparing meals or special diets
- acting as a companion or sitter, and
- supervising medication that can be self-administered

The Fund covers Home Health Aides. Home Health Aides provide patient care services such as:

- bathing the patient
- helping the patient get in and out of the shower, and
- helping the patient get dressed and changing the bed linen

Short-term Rehabilitation Services

The Fund covers short-term rehabilitation services and nursing home services only when used instead of hospitalization and the services have been pre-certified by Hines & Associates.

Home Hospice Care

Home hospice care is care for an illness for which the prognosis for life expectancy is estimated to be six months or less. Home hospice care provides pain control and symptom relief services.

All services must be medically necessary and appropriate for the care of the patient and must be pre-certified by Hines & Associates. Nurses and home health aides are covered in conjunction with home hospice care.

Highlights

The Fund may authorize the purchase of durable medical equipment (DME) if it is less expensive than the expected long-term rental cost.

Medical Supplies and Durable Medical Equipment

Durable medical equipment (DME) must be approved by the Medical Utilization Review vendor, Hines & Associates. The Fund may authorize the purchase of DME if it is less expensive than the expected long-term rental cost. The Fund covers the DME rental fee up to the purchase price of the DME.

DME is covered if it meets all the following requirements:

- It is medically necessary.
- It is prescribed by the attending physician.
- It is primarily and customarily used for a medical purpose.
- It is designed for prolonged use.
- It serves a specific therapeutic purpose in the treatment of an illness or injury.

What's Covered

The following are examples of medical supplies and DME that are covered by the Fund:

- ✔ rental of wheelchair, up to the purchase price or $3,500, whichever is less, or the rental of a hospital bed, up to the purchase price or $1,800, whichever is less. A request for a wheelchair where the cost will or may exceed $3,500, or a request for a hospital bed where the cost will or may exceed $1,800, must be pre-approved by the Fund and/or Hines & Associates and will be considered for approval only if less expensive alternatives are determined to be medically inappropriate.
- ✔ an appliance or device that replaces a lost body organ or part, or helps an impaired body organ or part to work (an example is an artificial limb or eye); however, any replacement of appliances requires Fund approval
- ✔ splints, crutches, braces, walkers or other supportive devices
- ✔ surgical supplies, such as bandages and dressings
- ✔ blood or blood plasma
- ✔ home infusion supplies
- ✔ oxygen and charges for giving it — including rental of required equipment
- ✔ osteotomy and catheter supplies
- ✔ portable toilets

What's Not Covered

In addition to the exclusions outlined in *What's Covered* above, the Fund does not cover:

- ⊘ exercise classes and/or exercise equipment
- ⊘ lift chairs
- ⊘ air conditioners, humidifiers, dehumidifiers and purifiers
- ⊘ three-wheeled mobility scooters

Fund Approval

You must call the Fund Office for approval of the items listed in the *About Pre-Certification and Prior Approval section,* page 25.

To request approval for medical supplies and DME, call the Fund Office. Failure to get Fund approval may result in a denial of benefits.

PRESCRIPTION DRUG BENEFITS

		YOU	SPOUSE	CHILDREN
Wage Class I	< 32	Y		
	≥ 32	Y	S	C
Wage Class II	< 32			
	≥ 32			
Wage Class III				

	RETAIL PHARMACY	MAIL SERVICE PHARMACY
WHEN TO USE	For a prescription drug used on a short-term basis For example: an antibiotic to treat strep throat	For a prescription drug used on a regular, ongoing basis For example: medication to treat chronic high blood pressure
SUPPLY PER PRESCRIPTION / REFILL	Up to a **30-day** supply	Up to a **90-day** supply
YOUR COST (PER PRESCRIPTION REFILL)	**Network Pharmacy:** • Generic — $10 co-pay • Brand Name — $30 co-pay **Non-participating Pharmacy:** • Generic — $10 co-pay • Brand Name — $30 co-pay **plus** • Any amount over the prescription network-allowed charge	$10 Generic $30 Brand Name

Retail Pharmacy

You can buy up to a 30-day supply of either brand name or generic prescription drugs.

How to Fill a Prescription

Show your prescription ID card to the pharmacist when you present your prescription. If you have difficulty at the pharmacy, ask the pharmacist to call Prescription Solutions, toll-free, at 1-800-788-7871. The phone number is also listed on your Prescription Drugs ID Card. Or you may call the Fund Office.

Using a Network Retail Pharmacy

When you use a Network pharmacy, there is no paperwork to complete. The Fund has contracted with Prescription Solutions and its Network pharmacies to provide prescription drugs at the network-allowed charge. You pay only the applicable co-pay at the time you purchase your prescription.

To find a Network pharmacy in your area, call the Fund Office, or:

- call Prescription Solutions, toll-free, at 1-800-788-7871
- visit the Prescription Solutions website at www.rxsol.com

Using a Non-participating Pharmacy

If you use a non-participating pharmacy, you will have to pay for the **full amount** of your prescription when it is filled and file a claim with Prescription Solutions for reimbursement of covered charges.

For complete information, see the *How Claims Are Filed* section, page 105.

Highlights

The Mail Service Pharmacy is not only easy and convenient, you save money because you pay one co-payment for a 90-day supply.

Mail Service Pharmacy

If you take the same medication for extended periods — more than 30 days — not only is the Mail Service Pharmacy easy and convenient because your orders are delivered to your door, you save money over buying the same prescription at a retail pharmacy. Under the Mail Service Pharmacy, you save money because the co-pay for a 90-day supply is the same as the co-pay for a 30-day supply purchased at the retail pharmacy.

You must register with the Prescription Drug vendor, Prescription Solutions, in order to participate in this service. To get a Mail Service Pharmacy Form call the Fund Office or:

- call Prescription Solutions, toll-free, at 1-800-788-7871
- the Fund Office at, toll-free, 1-800-227-4744, or in the Hartford area at 860-728-1100, or
- visit the Prescription Solutions website at www.rxsol.com

What Are Generic Drugs?

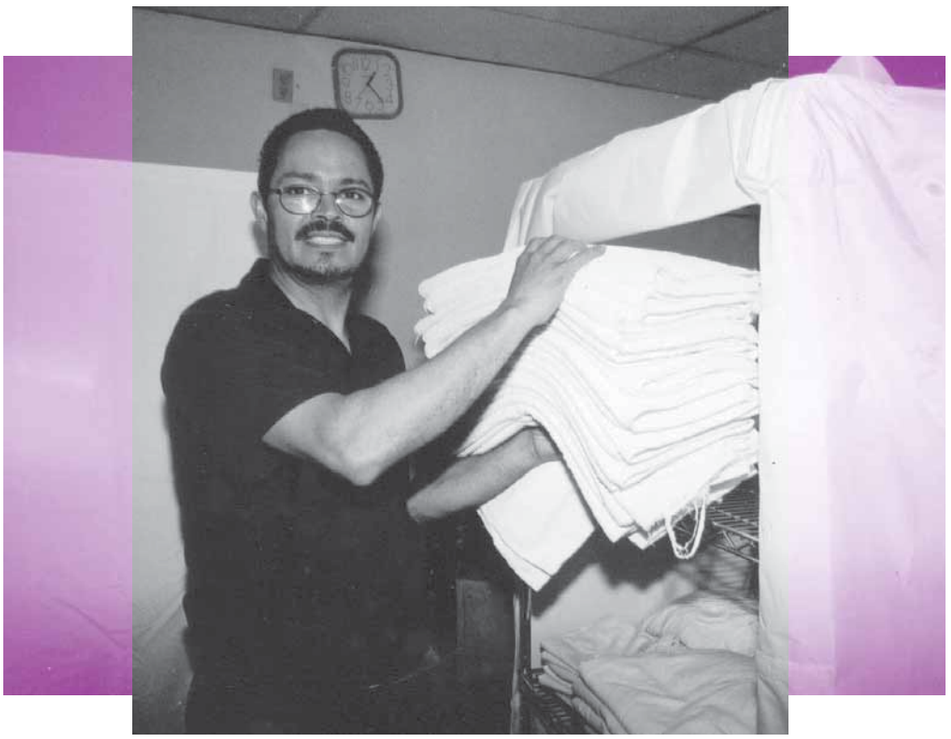
Generic drugs are essentially the same as brand name drugs. The main difference is the cost — generic drugs are normally cheaper. Federal law requires that generic drugs must contain the same active ingredients in the same quantities and be the same strength as the equivalent brand name drug. In addition, they must meet the same Food and Drug Administration (FDA) standards for safety and effectiveness before they are approved for use by the general public.

When your prescription is filled at the pharmacy, a generic equivalent will be substituted for a brand name drug if it is available, unless your physician writes "dispense as written" on the prescription form. If your physician has not written "dispense as written" and you request the brand name drug you will have to pay the $30 brand name co-pay and the difference between the cost of the generic drug and the brand name drug.

What's Not Covered

The following are not covered by the Fund's prescription drug benefit:

- **drugs given while confined in a hospital, nursing home or similar place** that has its own drug dispensary
- **drugs payable under another benefit of the plan** — except under the Medical benefit
- **over-the-counter or non-prescription drugs** — except for accepted diabetic supplies
- **non-prescription items such as bandages or heating pads** — even if your physician recommends them
- **off-label use of a drug** — prescriptions for drugs not approved by the FDA for the treatment of your condition are not covered by the Fund, except that the Fund, in its sole discretion, may approve off-label drug use provided that:
  - your treating physician prescribes a drug for your condition that in her/his professional judgment is both safe and effective, and
  - you sign a Waiver of Liability for the Fund



DENTAL CARE BENEFITS

		YOU	SPOUSE	CHILDREN
Wage Class I	< 32	Y		
	≥ 32	Y	S	C
Wage Class II	< 32			
	≥ 32			
Wage Class III				

The Fund has contracted with Delta Dental of New Jersey to provide your dental care benefits.

The following section is a summary of your dental coverage. For a complete description of covered and non-covered dental services, please refer to the booklet, *New England Health Care Employees Welfare Fund Dental Benefits Summary.* To request a copy of this summary booklet call the Fund Office.

Dental Care Services

	NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Annual Deductible (for Basic and Major Services only)	The first $50 per Individual or $150 per Family of dental cost each calendar year	The first $50 per Individual or $150 per Family of dental cost each calendar year
Annual Maximum	$1,000 per person per calendar year	
Preventive and Diagnostic Services	**You pay:** Nothing Covered services are paid in full	**You pay:** Only if the dentist's fee is above Delta's maximum allowable charge or the procedure is not covered
Basic Services	**You pay:** 20% co-insurance after deductible	**You pay:** 20% co-insurance after deductible **plus** amount of dentist's fee over network-allowed charge, if any
Major Services (Orthodontics is not covered)	**You pay:** 50% co-insurance after deductible	**You pay:** 50% co-insurance after deductible **plus** amount of dentist's fee over network-allowed charge, if any **Remember, you can be billed whatever the Out-of-Network provider charges.**

What's Covered

Your coverage under the Fund includes:

Preventive and Diagnostic Services

- ✔ **exams** - up to two exams per person per calendar year
- ✔ **cleanings** - up to two cleanings per person per calendar year
- ✔ **x-rays, full mouth series or panoramic** - either service, once every three years
- ✔ **x-rays, single films** - multiple x-rays on the same date of service, not to exceed the benefit of a full-mouth series
- ✔ **fluoride treatment** - one treatment per calendar year, for eligible children up to age 19
- ✔ **space maintainers** - once per space for missing posterior primary teeth, for children under age 14

Basic Services

- ✔ **consultations** - one consultation per specialty per calendar year
- ✔ **fillings**
- ✔ **extractions, oral surgery**
- ✔ **endodontics** - treatment of the inner part of the tooth
- ✔ **periodontics** - treatment of gum diseases
- ✔ **repair of dentures**
- ✔ **sealants** - for eligible children through age 14

Major Services

- ✔ **crowns** - age 12 and older
- ✔ **bridgework** - age 16 and older
- ✔ **full and partial dentures** - age 16 and older
- ✔ **inlays**

For all covered services, there is an Annual Maximum benefit of $1,000 per person per calendar year.

Using a Network Dentist

The Fund has contracted with Delta Dental to administer the dental care plan and to provide you and your eligible dependents with access to its networks of participating dentists — Premiere and Delta Dental PPO. Both networks are available under the plan.

To use a Network dental provider, follow these steps:

1. Check to see if you are eligible for dental benefits by calling the Fund Office.
2. Choose a dentist from the list of Network providers and call for an appointment.
3. Tell your dentist that you are covered under the 1199 Welfare Fund.
4. Take your Delta Dental ID Card with you when you go to see the dentist.

When your dental service is complete, your Network dentist will bill Delta Dental directly for your care:

- The Fund pays Delta Dental directly for covered services.
- Delta Dental pays your dentist for the Fund share of your covered dental charges.
- You will be billed by your dentist for your share of the cost, if any.

To get a current listing of Network providers call the Fund Office, or:

- call Delta Dental, toll-free, at 1-800-DELTA-OK (1-800-335-8265)
- visit the Delta Dental website at www.DeltaDentalnj.com

Using an Out-of-Network Provider

If you are treated by an Out-of-Network provider — a dentist who does not participate in the Delta Dental Network — you can be billed whatever the provider charges. An Out-of-Network provider may require full payment or may bill you for payment. If you are billed and pay the Out-of-Network provider, you have to submit a claim for reimbursement of covered charges.

For more information see the *How Claims Are Filed* section, page 105.

What's Not Covered

Orthodontic services are not covered. For a complete list of services not covered under the Delta Dental plan, please refer to the section *Exclusions and Limitations: Services Not Covered by This Dental Plan* in the booklet, *New England Health Care Employees Welfare Fund Dental Benefits Summary.*

If you have any questions concerning your dental care benefits, please call the phone number on your Delta Dental ID Card.

PC

Alert!
Pre-certification
is required.

VISION CARE BENEFITS

		YOU	SPOUSE	CHILDREN
Wage Class I	< 32	Y		
	≥ 32	Y	S	C
Wage Class II	< 32	Y		
	≥ 32	Y	S	C
Wage Class III		Y		

The Fund has contracted with Davis Vision to provide your benefits through a network of participating Vision Care providers. The following section is a summary of your coverage.

Vision Care Services

	NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Eye Exams (one exam every 24 months)*	**No charge to You** Services are covered in full	Maximum Benefit $16
Spectacle Lenses (one pair every 24 months)*		Maximum Benefit
Single refraction	**Covered – No charge to You**	$14
Bifocals	**Covered – No charge to You**	$23
Trifocals	**Covered – No charge to You**	$32
	Additional charges may apply for certain lens features.	
Frames (one every 24 months)*	**Covered – No charge to You**	Maximum Benefit $14
	Additional charges may apply for non-Davis Vision products.	
Contact Lenses (one pair every 24 months)*	$25 or $45 co-payment, depending on the type of lenses you require	Maximum Benefit $45
*** All services must be obtained at one time from one Network or one Out-of-Network provider.**		

What's Covered

Your vision care coverage includes:

- ✔ one eye exam **and** one pair of glasses or contact lenses once a year for eligible children to age 13, and
- ✔ one eye exam **and** one pair of glasses or contact lenses every two years for you and your covered dependents age 13 and older

Under this plan, you can choose to go to either one Network or one Out-of-Network provider and vision care services must be completed in one visit with that provider.

Whether you see a Network or Out-of-Network provider, you must call the Vision Care vendor, Davis Vision, toll-free, at 1-800-999-5431 to verify your next available service date. The phone number is also listed on your Medical ID Card.

Using a Network Provider

To use a provider that participates in the Davis Vision Network, you must:

- check your eligibility for vision care benefits by calling the Fund Office
- verify your next available service date by calling Davis Vision at the number listed on your Medical ID Card
- choose a provider and call for an appointment, and
- tell your provider that you are covered under the New England Health Care Employees Welfare Fund

When your vision care service is complete, your Network provider will bill Davis Vision directly for your care:

- The Fund pays Davis Vision directly for covered services.
- Davis Vision pays your provider for the Fund share of covered charges.
- You will be billed by the provider for your share of the cost, if any. There is an additional cost if you select vision care supplies that are not Davis Vision products.

To find a Network provider in your area:

- call Davis Vision, toll-free, at 1-800-999-5431, or
- visit the Davis Vision website at www.DavisVision.com

Using an Out-of-Network Provider

If you choose an Out-of-Network provider, you will have to pay for the **full amount** of your vision care services and supplies at the time of service, and then file a claim with Davis Vision for reimbursement of covered expenses.

For more information, see the *How Claims Are Filed* section, page 105.

What's Not Covered:

The following services are not covered under the Davis Vision plan:

- medical treatment of eye disease or injury — this is covered under the Fund's Medical benefits
- vision therapy
- special lens designs or coatings
- replacement of lost eyewear
- non-prescription (plano) lenses
- frames other than Davis Vision products

WHAT'S NOT COVERED — EXCLUSIONS AND LIMITATIONS

The Fund does not cover all health care services. If you have questions about any medical treatment you are considering, please call the Fund Office.

In addition to the various exclusions discussed elsewhere in this SPD, the Fund does not cover:

1. **Claims submitted more than 12 months after the date of service**
2. Services that are not medically necessary
3. An illness or injury that was deliberately self-inflicted or that resulted from participating in an illegal act
4. An illness or injury resulting from the conduct of another person, where payment for those charges is the legal responsibility of another person, firm, corporation, insurance company, payor, uninsured motorist fund, no-fault insurance carrier or other entity
5. Blood and blood plasma donated, replaced or stored for future use. Storage of patient's blood for an imminent surgery is covered
6. Charges for orthoptics — eye muscle exercises
7. Charges over the Fund's allowable amounts
8. Organ transplants — transplants considered to be experimental are not covered by the Fund. Charges related to donating an organ for transplanting are not covered. Contact the Fund Office for details of coverage for receipt of an organ transplant.
9. Charges for services provided before you or your dependents become covered by the Fund
10. Charges to correct refraction errors of the eye, including any confinement, treatment, services or supplies
11. Complications arising from non-covered services
12. Convalescent facilities, nursing homes, skilled nursing facilities, group homes, halfway houses and rest homes — the Fund does cover short-term rehabilitation services and nursing homes only when used instead of hospitalization and when pre-certified by the Medical Utilization Review vendor
13. Education, training, bed and board while confined in an institution that is mainly a school or other institution for training
14. Cosmetic treatment or surgery that is not medically necessary, except to remedy a disfigurement that results from an accidental injury that occurred while covered by the Fund or treatment or surgery that is mandated by the Womens' Health and Cancer Rights Act
15. Custodial care — care that assists the individual in meeting the activities of daily living but does not require professional medical personnel
16. Dependent child: pregnancy, infertility or sterilization, including diagnostic tests, abortions or other related charges

17. Exercise classes, figure salons, resorts, spas, camps or membership fees
18. Exercise equipment, air conditioners, air purifiers, humidifiers or any similar devices — except for a humidifier specifically designed for attachment to a Continuous Positive Airway Pressure (CPAP) machine. The humidifier and CPAP machine must be pre-authorized by the Fund
19. Experimental, investigational or unproven medical procedures, treatments, devices, drugs or services
20. Home nursing care, except in place of hospitalization and when pre-certified by the Medical Utilization Review vendor
21. Hypnosis for any reason
22. Infant formula; nutritional supplements and liquid food, regardless of age
23. Infertility — any treatment for infertility, other than charges associated with the diagnosis of infertility, is not covered
24. Injury or sickness caused by war or international armed conflict
25. Injuries or diseases sustained in any occupation or employment for pay or profit — see the *Workers' Compensation* section, page 119
26. Interest, late charges, finance charges, court or other legal costs
27. Lift chair
28. Non-prescription items such as bandages or heating pads, even if your physician recommends or prescribes them
29. Nutritionists — services of a nutritionist are covered under the Fund only when ordered by the treating physician for a covered medical diagnosis
30. Naturopaths, Homeopaths and Holistic practitioners and their products are not covered
31. Obesity treatment, including surgery and surgical complications — morbid obesity is covered only if there is a secondary diagnosis other than morbid obesity
32. Over-the-counter drugs — except for standard diabetic supplies
33. Penalties or exclusions incurred under a primary plan because the participant didn't follow another health care plan's rules
34. Physical examination required by an employer as a condition of employment or by a school or camp as a condition of enrollment or participation
35. Pregnancy delivery preparation classes
36. Services or prescriptions for drugs not approved by the FDA for the treatment of your condition, unless approved by the Fund as set forth on page 63.
37. Rehabilitation facilities, unless pre-approved by the Medical Utilization Review vendor

38. Reversal of sterilization
39. Routine foot care — such as trimming nails and removing corns or calluses — except if the patient is diabetic or on physician-prescribed blood thinners (anticoagulants)
40. Scooter, including a three-wheeled mobility scooter
41. Services or supplies furnished by a person related by blood, marriage, adoption, or any household members
42. To the extent permitted by law, services, treatments and supplies covered under any other insurance coverage or plan, or under a plan or law of any government agency or program
43. Transsexualism — any procedures, services, supplies, treatment, surgery or medications related to the treatment for transsexualism
44. Temporomandibular Joint (TMJ) Dysfunction or Syndrome (also called myofascial pain dysfunction) — all services related to diagnosis and treatment, both medical and surgical
45. Treatment for any normal hair loss (baldness), hair removal or hair transplants
46. Vitamins, except for vitamins prescribed for and taken during pregnancy
47. Vision training or subnormal vision aids
48. Weight reduction programs or dietary supplements for weight loss
49. Wigs — except if needed due to chemotherapy or radiation therapy, in which case you are covered for up to two wigs per calendar year, to a maximum of $350 per wig
50. Any service or supply not listed as covered in this SPD booklet

SHORT-TERM DISABILITY (STD) BENEFITS

		YOU	SPOUSE	CHILDREN
Wage Class I	< 32	Y		
	≥ 32	Y		
Wage Class II	< 32	Y		
	≥ 32	Y		
Wage Class III		Y		

When you are unable to work due to a non-work related injury or illness while covered by the Fund, your short-term disability coverage provides you with weekly income. **While you are receiving short-term disability benefits you will remain eligible for the level of Fund benefits for which you were eligible at the onset of the disability.**

Although the Fund does not cover a work-related injury or illness, the Fund will advance short-term weekly disability benefits to you if your claim is disputed by your employer's insurance carrier and is pending before the Workers' Compensation Commission. The Fund will recover those advances from your recovery in the Workers' Compensation case.

If you are eligible for short-term disability, your weekly benefit is paid according to the following schedule:

Benefit Amount:
Two-thirds of your average earnings, based on the larger of:

- your average weekly earnings for the eight-week period immediately prior to your disability or
- your current weekly wages

Maximum Benefit:
$300 per week, less Medicare and FICA withholding taxes

Payment Period:
Up to a maximum of 26 weeks in any 52-week period

Highlights

You may be eligible to receive up to a maximum of 26 weeks of disability payments in any 52-week period.

Who's Covered

To be eligible for short-term disability payments, you must meet all eligibility requirements of a covered member and be actively employed at the onset of the disability.

You are eligible to receive a weekly disability benefit if you are:

- unable to work at your regular job because of a non-work related injury, illness or pregnancy, and
- determined by your licensed physician to be totally disabled from performing the duties of your regular job

Accident Claims

If your disability may be due to an accidental injury, such as a motor vehicle accident, an accident questionnaire will be sent to you. You must complete the form and return it to the Fund Office.

If you bring a liability claim against any third party, benefits paid by the Fund must be included in the claim, and when the claim is settled, you must reimburse the Fund for the benefits provided. For more information, see the *Accident Claims* section, page 115.

For a disability due to a work-related injury or illness, see the *Workers' Compensation* section, page 119.

Highlights

There is a 15-calendar-day waiting period starting on the first day your physician determines that you are totally disabled and unable to work.

Payments

Start of Payments

Payment of disability benefits does not start at the beginning of the disability. There is a 15-calendar-day waiting period starting on the first day your physician determines that you are totally disabled and unable to work. Benefits start on the 16th calendar day of disability.

Number of Payments

If your disability is non-work and non-pregnancy related, you are eligible to receive disability benefits for up to a maximum of 26 weeks in any 52-week period.

Number of Payments for Disability Due to Pregnancy

If your disability is due to pregnancy, the maximum number of disability payments is six weeks for a normal delivery and eight weeks for a cesarean delivery (see table below) subject to the 15-day waiting period regardless of whether the waiting period occurs before or after delivery.

TYPE OF DELIVERY	MAXIMUM BENEFIT PERIOD
Normal delivery	6 weeks - subject to the 15-day waiting period
C-section	8 weeks - subject to the 15-day waiting period

For example, if you are unable to work seven days before you deliver your baby naturally, your 15-day waiting period will start seven days before you deliver and end eight days after you deliver.

If there is a separate diagnosis of disability during the term of the pregnancy, you may be eligible for the additional weeks of disability up to the maximum of 26 weeks.

Before you stop working, call the Fund Office to make sure you are eligible for benefits.

End of Payments

Payment of your disability benefits ends on **the earliest of** the following:

- the date you are determined to be no longer disabled
- the date you return to work, or
- when the maximum payment period ends:
  - 26 weeks in any 52-week period, or
  - 6 or 8 weeks for pregnancy

New Period of Disability

The maximum 26-week payment period in any 52-week period begins on the first day your health care provider determines you are disabled. If you receive the maximum 26 weeks disability, you will not be eligible for a new period of disability until the 52-week period has been met:

Example	
Start of disability:	March 3, 2007
Disability payments received:	26 weeks
Eligible for new period of disability benefits:	March 3, 2008

After an initial period of disability benefits, a new 15-calendar-day waiting period is determined by:

- the length of time you return to work before going back out on disability, and
- the reason for the additional period of disability

To see if a new 15-calendar-day waiting period is required, please refer to the following table:

If you return to work after an initial period of disability, and…

YOU RETURN TO WORK FOR:	AND BECOME DISABLED AGAIN AS THE RESULT OF:	THEN THERE IS:
less than 13 weeks	the same pregnancy or non-work related injury or illness	no additional waiting period.
less than 13 weeks	a different pregnancy or non-work related injury or illness	a new 15-calendar-day waiting period
more than 13 weeks	the same pregnancy or non-work related injury or illness	a new 15-calendar-day waiting period

Filing a Claim

For complete information, see the *How Claims Are Filed* section, page 105.

Disability Claims Deadline

All disability claims must be submitted to the Fund Office within one year of the beginning of the period of disability.

End of Disability

The Fund will send you an End of Disability Notice with the last disability payment. Once disability payments have ended your health care coverage under the Fund will end, unless you:

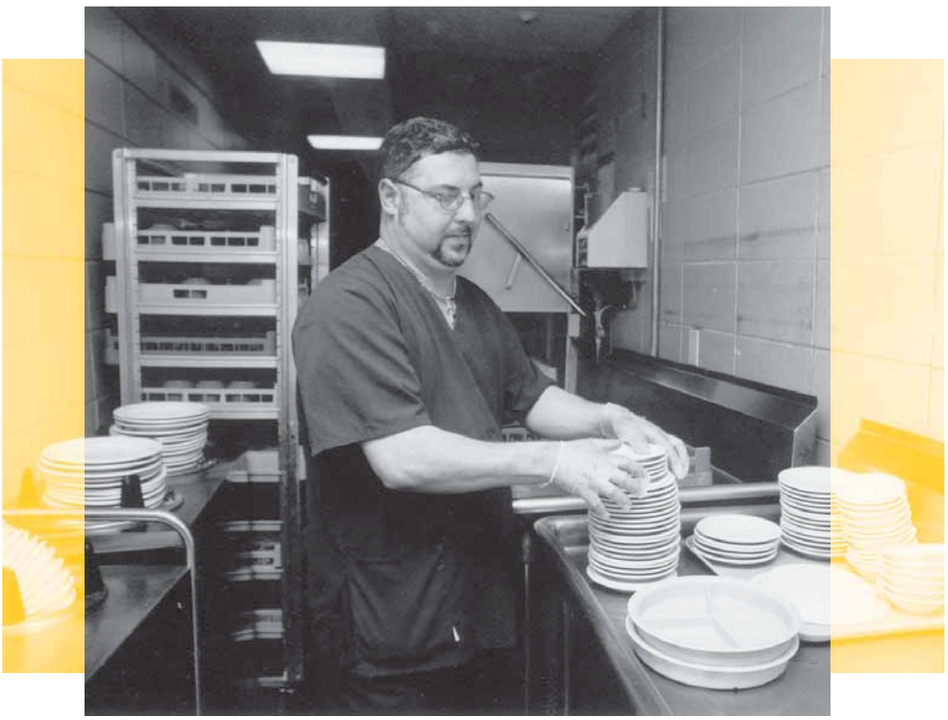
- return to work and work sufficient hours for your employer to be required to make Fund contributions on your behalf
- go on Family Medical Leave Act (FMLA) leave and your employer continues to make Fund contributions on your behalf
- use sufficient paid vacation or sick time to require contributions from your employer
- elect COBRA continuation health care coverage

Light Duty

You will continue to be eligible for short-term disability coverage, subject to the Fund's maximum 26 weeks in any 52-week period, if:

- you return to work but are unable to perform your regular duties due to a non-work related injury, illness or a pregnancy, and
- your employer does not offer light duty to you

Your employer must send to the Fund written documentation on employer letterhead stating that the employer does not offer you light duty.



LIFE INSURANCE BENEFITS

		YOU	SPOUSE	CHILDREN
Wage Class I	< 32	Y		
	≥ 32	Y		
Wage Class II	< 32	Y		
	≥ 32	Y		
Wage Class III		Y		

Your life insurance benefit is intended to provide your surviving family members with some income to help them through a difficult adjustment period.

Your benefit amount depends on:

- your wage class
- your length of Fund participation, and
- your earnings

Life Insurance Schedule

YOUR WAGE CLASS	YOUR YEARS OF FUND PARTICIPATION	YOUR LIFE INSURANCE BENEFIT AMOUNT
Wage Class I	less than one year	$2,000
	one or more years	an amount equal to your annual earnings for the prior year, as reported to the Fund by your employer, rounded to the nearest multiple of $1,000 Maximum benefit: $25,000
Wage Class II	less than one year	$2,000
	one or more years	$4,000
Wage Class III	less than one year	$2,000
	one or more years	$2,000

Payment of Benefit

If you die while covered by the Fund, your life insurance benefit amount will be paid to your beneficiary(ies).

Your Beneficiary

Important Term

Your **beneficiary** is the person you name on your Fund Enrollment Form to receive payment of your life insurance benefit if you die while covered by the Fund. You can name one or more people as a beneficiary.

Naming Your Beneficiary

When you first enroll in the Fund, you are asked to name your beneficiary on the Enrollment Form. You may name more than one person to share any life insurance benefit by listing each person on the form and indicating, by percentage, how the life insurance amount is to be divided among them. If you do not enter a percentage for each beneficiary, they will share the benefit equally.

All rights and claims to benefits of any beneficiary end should she/he die before you do.

The benefit will be paid to the executors or administrators of your estate if:

- you never named a beneficiary,
- none of your named beneficiaries are alive at the time of your death, and
- there are no surviving relatives

If there is no executor or administrator, the Fund may, at its option and in this order:

- pay the benefit to your surviving spouse
- if there is no living spouse, pay equal shares of the benefit to your surviving children
- if there are no living children, pay the benefit in equal shares to your surviving parents

Changing Your Beneficiary

Important Term

You may **change your beneficiary** at any time by completing a Change of Enrollment Form and returning the form to the Fund Office. You can get this form by calling the Fund Office.

Your Change of Enrollment Form must be **received and recorded** by the Fund Office before the change of beneficiary becomes effective.

Assignment of Benefits

The life insurance benefit is payable only to your named beneficiary(ies) on the form on record in the Fund Office. This means you may not assign or transfer the life insurance benefit to anyone else. However, the Fund will allow a Funeral Assignment if requested in writing by ***all*** named beneficiaries.

Conversion to an Individual Life Insurance Policy

Right to Convert

Important Term

If your coverage under the Fund's life insurance plan ends or the benefit is reduced under certain circumstances, you may have a **right to "convert"** your coverage under this group insurance coverage to an individual policy. Your right to convert means that you do **not** have to provide evidence of insurability — also known as evidence of health — in order to obtain your personal policy.

Changes in Your Status

If your life insurance benefit terminates or is reduced because:

1. you cease to be eligible for benefits as described in the *When Your Benefits End* section, page 127, or
2. you transfer to a wage class that offers lesser benefits, or
3. you reach the age at which the group policy requires your life insurance benefit to be reduced

... you can convert your group life insurance coverage to an individual policy.

Although evidence of your health is not required, you must apply in writing and pay the first premium to the insurer **within 31 days** from the date your group life insurance coverage by the Fund ends or is reduced.

If you want to convert your group insurance coverage to an individual policy, call the Fund Office.

Individual Policy

An individual who is eligible to convert is entitled to convert to any individual policy that is then being offered by the insurer. However, the individual policy will not be insurance that provides disability or other supplemental benefits.

If you choose to convert to an individual policy, the amount of your policy may equal or be less than the amount of your Fund group life insurance benefit that ended or was reduced. The premium you pay will be determined by the insurer based on the type of policy and amount of your policy, as well as your class of risk and age on its effective date.

Group Policy Termination or Change

Your life insurance coverage by the Fund may end because the group policy is terminated by the Trustees. If this happens, you have the right to obtain an individual life insurance policy if:

- you have been covered by the Fund for at least five years
- the amount of your individual policy will not be more than $2,000, and
- your life insurance coverage by the Fund will not be fully replaced by another group insurance plan within the next 31 days

Death While Eligible to Convert

If you convert to an individual policy, your individual coverage will become effective 31 days from the date your group life insurance coverage under the Fund ends.

If you should die before your individual policy becomes effective, a death benefit will be paid by the Fund. The amount of this benefit will be the full amount you were entitled to under the individual policy. The benefit will be paid to the beneficiary(ies) you last named with the Fund or on your individual conversion policy.

Waiver of Premium Provision

If you become totally and permanently disabled before age 60, and you comply with the requirements outlined below, your life insurance benefit may continue in force for one year as long as you remain totally and permanently disabled. There will be no cost to you.

Total and permanent disability regarding **life insurance** benefits means your complete inability to engage in any occupation or employment for which you are or become qualified by reason of education, training or experience and you are not in fact engaged in any occupation or employment for pay or profit. To be considered permanently disabled you must provide a letter from your physician stating that your physician believes your total disability is permanent or will continue for at least one year.

In order for your life insurance benefit to continue under this provision, you must complete an application for Waiver of Premium that is approved by the insurance carrier, and you must remain totally and permanently disabled as described above. The application must include acceptable proof of your total and permanent disability, in writing, and must be received by the Fund **within the 12-month period** following the date that your short-term disability income benefit from the Fund ends or within 12 months following the date you became totally and permanently disabled, whichever is later.

The initial proof you provide must show that the total disability:

1. began while you were covered by the Fund
2. began before you reached age 60, and
3. has existed continuously for six consecutive months

Continuance of Waiver of Premium

When the Fund receives acceptable proof, your life insurance may be continued for additional consecutive 12-month periods if:

1. you remain totally and permanently disabled, and
2. you provide to the Fund Office acceptable written proof of your continued total and permanent disability **each year** within the three-month period immediately before the anniversary date the Fund Office received your initial proof of total disability

Your life insurance benefit will end 31 days after the date your total and permanent disability ends, unless you return to active employment with a participating employer who is obligated to make contributions to the Fund on your behalf.

If the life insurance benefit provided by the Fund has a scheduled reduction in benefits at certain ages or times — for example, at retirement — the reductions will apply to you even if you are totally and permanently disabled.

If your life insurance coverage by the Fund ends, you may be eligible to have your life insurance converted to an individual policy. In this case, you are responsible to pay the full premium amount.

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFITS

		YOU	SPOUSE	CHILDREN
Wage Class I	< 32	Y		
	≥ 32	Y		
Wage Class II	< 32	Y		
	≥ 32	Y		
Wage Class III		Y		

In addition to your short-term disability and life insurance coverage, you have added income protection provided by the Fund's Accidental Death, Dismemberment and Loss of Sight Insurance, also known as AD&D insurance.

Your benefit amount depends on:

- your wage class
- your length of Fund participation, and
- your earnings

AD&D Schedule

YOUR WAGE CLASS AT THE TIME OF YOUR AD&D EVENT	YOUR YEARS OF FUND PARTICIPATION	YOUR AD&D INSURANCE BENEFIT AMOUNT
Wage Class I	less than one year	$2,000
	one or more years	an amount equal to your annual earnings for the prior year, as reported to the Fund by your employer, rounded to the nearest multiple of $1,000 Maximum benefit: $25,000
Wage Class II	less than one year	$2,000
	one or more years	$4,000
Wage Class III	less than one year	$2,000
	one or more years	$2,000

Accidental Death

The Fund will pay a non-work related accidental death benefit if your death occurs under the following conditions:

- the death is a result of a non-work related accidental injury
- the injury occurred while you were insured by this coverage, and
- the death occurred within 180 days of the injury

The AD&D benefit is paid in addition to the life insurance benefit.

Filing a Claim

In order to file a claim, a family member must contact the Fund within 90 days after your accidental death. The Fund will send a Proof of Death Claim Form to the person making the claim. The written proof of loss must include the information listed below.

Proof of Death

Proof of death must be submitted to the Fund within 90 days after your accidental death. A claim will not be reduced or denied if proof is not provided within this time, if it was not feasible to provide the proof, and the proof was provided as soon as it was feasible.

The proof of death claim must include all information necessary for the Fund to determine the type and the date of the accidental death. The Fund may require, as part of the proof, authorization to obtain certain medical and non-medical information.

Payment of Benefit

This accidental death benefit amount will be paid to your named beneficiary(ies) when the Fund receives proof that your death occurred under the conditions stated above and your claim is approved by the insurer.

Your Beneficiary

Your beneficiary is the person you named **on the Enrollment Form** to receive payment of your life insurance benefit if you die while covered by the Fund. You can name one, two or more people as a beneficiary. For naming and changing your beneficiary, see the *Life Insurance Benefits* section, page 83.

Dismemberment and Loss of Sight

While covered by the Fund, if you have a non-work related accidental injury that results in the permanent loss of use of a limb or eye, within 180 days after the date of the accident, you will be paid as follows:

IN THE EVENT OF THE PERMANENT LOSS OF:	YOUR BENEFIT IS:
• both hands • both feet • sight of both eyes, or • any combination of foot, hand or sight of one eye	The full AD&D amount as described in the chart on page 89, according to your wage class and years of Fund participation
• one hand • one foot, or • sight of one eye	One-half of the full AD&D amount as described in the chart on page 89, according to your wage class and years of Fund participation

If you suffer more than one loss in any one accident, you will be paid only for the loss that has the larger payment.

A surgically reattached hand or foot will be considered a "permanent loss" if, 12 months after reattachment, the limb has regained less than 50% of its normal function.

Filing a Claim

In order to file a claim, you must contact the Fund within 90 days after the date of the loss. The Fund will send a statement of claim (for dismemberment/loss of sight) form to you. The written proof must include the information listed below.

Proof of Loss

Proof of loss must be submitted to the Fund within 90 days after the date of loss. A claim will not be reduced or denied if proof is not provided within this time, if it was not feasible to provide the proof, and the proof was provided as soon as it was feasible.

The proof of claim must include all information necessary for the Fund to determine the cause of the loss and the date of the loss.

The Fund may require, as part of the proof, authorization to obtain certain medical and non-medical information.

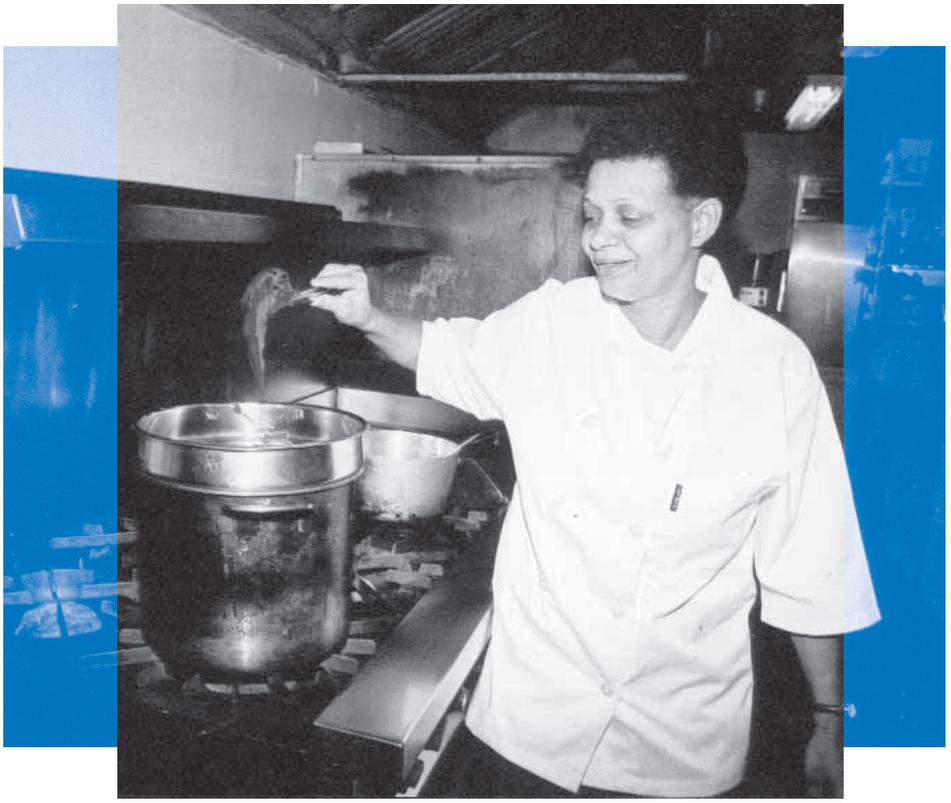
Payment of Benefit

The dismemberment/loss of sight benefit is paid directly to you.

What's Not Covered

No payment will be made for any loss caused directly or indirectly, or in whole or in part, by any of the following:

- bodily or mental illness or diseases of any kind
- medical or surgical treatment of an illness or disease
- suicide or attempted suicide
- intentional self-inflicted injury
- participation in the commission of a felony
- war or act of war, declared or undeclared; or any act related to war, or insurrection



SCHOLARSHIP BENEFIT

	YOU	SPOUSE	CHILDREN
Wage Class I	< 32		
	≥ 32		C
Wage Class II	< 32		
	≥ 32		
Wage Class III			

The Fund offers a Scholarship Benefit program to help your eligible dependents continue their education. The amount of the scholarship benefit depends on the number of applicants. At present, the average scholarship awarded is $500 per applicant per year.

Who Is Eligible?

To qualify for the scholarship benefit, you must, for the one-year period immediately before the time the scholarship award is granted, have been eligible for:

- Wage Class I benefits, and
- dependent coverage from the Fund

In addition, your dependent child must:

- be a full-time student — taking 12 or more credits per semester
- be an entering freshman or a continuing student in college
- submit a full-time Student Verification letter to the Fund twice each year (once in September and once in February)

Highlights

Scholarship applications are available each April 1.
Completed applications must be submitted to the Fund Office by each July 15.

Application Procedures

Application

Applications are available beginning each April 1 by calling the Fund Office.

Procedures

When you receive the scholarship application, you will also receive a schedule of dates for submitting required documentation to the Fund. Your dependent child must complete the application and return it to the Fund Office by July 15.

In addition to the completed application, you must submit to the Fund Office the following documents:

- **Full-time students entering their freshman year in a college or university**
  - a copy of their most recent **high school transcript, stamped with the offical school seal**
  - a letter of recommendation from a teacher or guidance counselor stating that the student is a good candidate for the scholarship
  - the college Student Verification letter, which must include: the semester dates of attendance, confirmation of full-time student status (12 or more credits), year of expected graduation and the **official school seal**

- **Full-time continuing students already in a college or university**
  - a copy of their most recent **college transcript, stamped with the official school seal**
  - the college Student Verification letter, which must include: the semester dates of attendance, confirmation of full-time student status (12 or more credits), year of expected graduation and the **official school seal**

When all of the documents are received and both participant and dependent eligibilities are verified, the Fund will send a scholarship check to you, the Fund participant, by the end of October. The scholarship check will not be sent until the Fund receives the college Student Verification letter. Scholarships are granted once per year.

Application Due Date

Completed scholarship applications are due back in the Fund Office no later than July 15 of each year.

You Must Reapply Each Year

If your child is a full-time continuing student and received a scholarship for the past scholastic year, she/he must reapply for scholarship benefits each year they are eligible.

Note: If your dependent child is a full-time student past the age of 19, you may continue Fund eligibility for health care benefits for that dependent. For more information see *Special Dependent Coverage Rules for 19- to 22-year-old Students* section, page 121.

MEDICARE SUPPLEMENT PLAN

The Fund Office can help you make the right choices regarding your health care benefits and your retirement. Contact the Fund Office if you are planning to retire in the near future.

General Eligibility

If you were a participant in the Fund prior to January 1, 1992, you may be eligible for Retiree benefits **at no cost to you**.

To be eligible, your employer, your bargaining unit and you must have:

- participated in the Fund prior to January 1, 1992, and
- had continuous employment with a participating employer before January 1, 1992, until immediately prior to your retirement

Highlights

As a regular retiree, you must be enrolled in both Medicare Parts A and B to be eligible for the Fund Medicare Supplement Plan.

Who Is eligible for the Medicare Supplement Plan?

Regular retirees are eligible for the Medicare Supplement Plan. You are a regular retiree if:

- you retire at or after age 65
- your employer, your bargaining unit and you were participating in the Fund before January 1, 1992, and
- you have had continuous employment with a participating employer before January 1, 1992, until immediately prior to your retirement

You must enroll for both Medicare Part A and Part B coverage. If you are an early retiree or a disabled retiree, see the *Direct Pay Plan* section, page 101.

Spouses of Regular Retired Employees

Your dependent spouse (including Civil Union partners, same-sex marriage partners and same-sex domestic partners) will be eligible for the following benefits if she/he was eligible for dependent coverage from the Fund immediately preceding your retirement date.

If your dependent spouse is:

- **under age 65,** your spouse will be allowed to self-pay for coverage under the Direct Pay Plan — the same benefits offered to a COBRA eligible person. When your spouse becomes eligible for Medicare, she/he will be eligible for the same Medicare Supplement benefits offered to you, or
- **age 65 or older,** your spouse will be eligible for the same Medicare Supplement benefits offered to you

Spouse of Deceased Regular Retiree

If you are a regular retiree receiving the Medicare Supplement Plan, the Fund will continue to cover your spouse under the Medicare Supplement Plan in the event of your death. In this case, your spouse will become a participant in the Fund and will be given her/his own ID number.

If You Don't Meet the Requirements for the Medicare Supplement Plan

If you don't meet the requirements for retiree benefits, the Fund will offer you COBRA continuation coverage. See the *COBRA* section, page 129.

Medicare Supplement Plan Benefits

As a regular retiree (retiring at age 65 or older) you must be enrolled in Medicare Parts A and B in order to be eligible for the Fund Medicare Supplement Plan.

When you are covered by Medicare Part A and Part B, the Fund provides benefit coverage as a Medicare Supplement Plan. Medicare is your primary insurance plan. Medicare pays 80% on covered services.

After Medicare has paid covered expenses, the Fund pays 80% of the **unpaid balance** of Medicare covered services. The Fund also pays for covered prescription drugs, vision care and reduced life insurance benefits if you were eligible for these benefits immediately prior to retiring.

If you have any questions or need more information on Medicare:

- call Social Security, toll-free, at 1-800-772-1213
- visit the Social Security website at www.ssa.gov

Note: Children of retirees are not covered by the Medicare Supplement Plan.

MEDICARE SUPPLEMENT PLAN SCHEDULE OF BENEFITS

If you and your spouse meet the eligibility requirements, once Medicare has paid its share of covered services, the Fund will pay 80% of the **unpaid balance** of the Medicare-approved amount for the following services:

- ✔ Ambulance
- ✔ Ambulatory Surgical Centers services
- ✔ Anesthetic expenses
- ✔ Chemotherapy
- ✔ Diagnostic (laboratory and x-ray) charges are covered **only if the diagnosis is related to surgery or an inpatient hospital admission**
- ✔ Emergency room visit and same-day services in connection with the ER visit — such as diagnostics, ER doctor visit
- ✔ Hemodialysis
- ✔ Hospital charges for outpatient surgery
- ✔ Hospital room and board (semi-private accommodations)
- ✔ Inpatient rehabilitation
- ✔ Medical supplies and DME (durable medical equipment)
- ✔ Medicare allowable behavioral health treatment
- ✔ Miscellaneous hospital expenses
- ✔ Nursing services (with prior approval)
- ✔ Physical therapy
- ✔ Physician charges and office and hospital visits are covered **only if the diagnosis is related to surgery or an inpatient hospital admission**
- ✔ Pre-admission testing, if the tests are performed no more than 14 days prior to an inpatient hospital admission
- ✔ Radiation therapy

Exclusions:

The following benefits are not covered:

- ⊘ Dental care
- ⊘ Hearing aid appliance
- ⊘ Laboratory and x-ray charges not related to surgery or an inpatient hospital admission
- ⊘ Office visits not related to surgery or an inpatient hospital admission
- ⊘ Skilled nursing facilities

The above information is only a brief summary; for more information please call the Fund Office.

Prescription Drug Coverage

Prescription drug benefits will continue for you and your eligible spouse as long as you were eligible for prescription drug benefits **immediately before your retirement** at or after age 65. This means that you must be in Wage Class I immediately prior to your retirement in order to continue to receive prescription drug benefits after you retire. See the *Prescription Drug Benefits* section, page 61.

Medicare Prescription Drug Coverage (Part D)

Starting January 1, 2006, Medicare prescription drug coverage is available to all persons covered by Medicare. However, if you and your eligible spouse are eligible for Fund prescription drug benefits, you do not need to enroll in a Medicare drug plan because the Welfare Fund already provides you with retiree prescription drug coverage that is better and less expensive ("creditable" coverage).

Your Fund prescription drug plan costs are significantly less than the cost of the standard Medicare prescription drug plan: you do not have to pay a premium for coverage, and there is no annual deductible and no annual benefit maximum under the Fund benefit. Your only cost for your Fund prescription drug plan is a $10 co-pay for generic drugs and a $30 co-pay for brand name drugs.

Vision Care Coverage

Your vision care benefits will continue for you and your eligible spouse, **except** if you are in Wage class III immediately prior to your retirement. In this case, there is no vision care coverage for your spouse. See the *Vision Care Benefits* section, page 69.

Dental Coverage

No dental coverage is provided.

Lifetime Maximum Benefit

The lifetime maximum benefit for retired participants is $500,000. This includes benefits paid when you were an active employee.

Example

For example, the Fund paid $300,000 for claims submitted by Mary Jones when she was an active participant. Now that Mary Jones has retired, she has a $200,000 lifetime maximum for paid claims under her regular retiree coverage.

Life Insurance Benefit

The schedule of life insurance benefits under the Fund is as follows:

Regular and Disabled Retirees

IN YOUR...	YOUR LIFE INSURANCE BENEFIT AMOUNT IS...
First year of retirement	$12,000
Subsequent years of retirement	Reduced by 20% each year. Minimum benefit amount is $2,500.

Early Retiree

IN YOUR...	YOUR LIFE INSURANCE BENEFIT AMOUNT IS...
First and subsequent years of retirement	$2,000

DIRECT PAY PLAN

For Early Retirees and Disabled Retirees

General Eligibility

If you were a participant in the Fund prior to January 1, 1992, you may also be eligible for Early Retiree or Disabled Retiree Benefits.

To be eligible, your employer, your bargaining unit and you must have:

- participated in the Fund prior to January 1, 1992, and
- had continuous employment with a participating employer before January 1, 1992, until immediately prior to your retirement

Summary

The Direct Pay Plan is offered to eligible early retirees and disabled retirees and their eligible spouses. Under this coverage, you pay the cost of coverage directly to the Fund in order to continue health care coverage until the earlier of:

- the date you reach age 65, or
- the date you become eligible for Medicare

If you continue to purchase Direct Pay coverage until age 65, you will automatically be enrolled in the Medicare Supplement Program. However, if you do not continue Direct Pay coverage until age 65, you and your eligible spouse will not be eligible for the Fund's Medicare Supplement Benefits when you turn 65.

Early Retiree

You are an early retiree if:

- you retire at age 55 or older but before age 65
- you are no longer working for a contributing employer
- your employer, your bargaining unit and you were participating in the Fund before January 1, 1992, and
- you have had continuous employment with a participating employer before January 1, 1992, until immediately prior to your retirement

When you retire early, the Fund will send you a Direct Pay Election Notice to complete and return to the Fund Office if you want to continue your health care coverage.

If you elect the Direct Pay Plan and pay the monthly premiums for the same Wage Class benefits that you had immediately before your retirement, you will continue the same medical coverage until you reach age 65. **However, if there is a change in Fund benefits for active participants, this change will also apply to Direct Pay eligible retirees.**

Disabled Retiree

You are a disabled retiree if, prior to age 65, you become unable to perform any gainful employment, as established by your treating physician and/or the Fund's medical consultant, and:

- you are currently receiving disability benefits under the federal Social Security Act, and
- your employer, your bargaining unit and you were participating in the Fund before January 1, 1992, and
- you have had continuous employment with a participating employer before January 1, 1992, until immediately prior to your retirement

When you become permanently and totally disabled, you and your spouse are eligible to elect Direct Pay until you and your spouse reach age 65 and become eligible for the Medicare Supplement Plan. The Fund will send you a Direct Pay Election Notice to complete and return to the Fund Office if you want to continue your health care coverage.

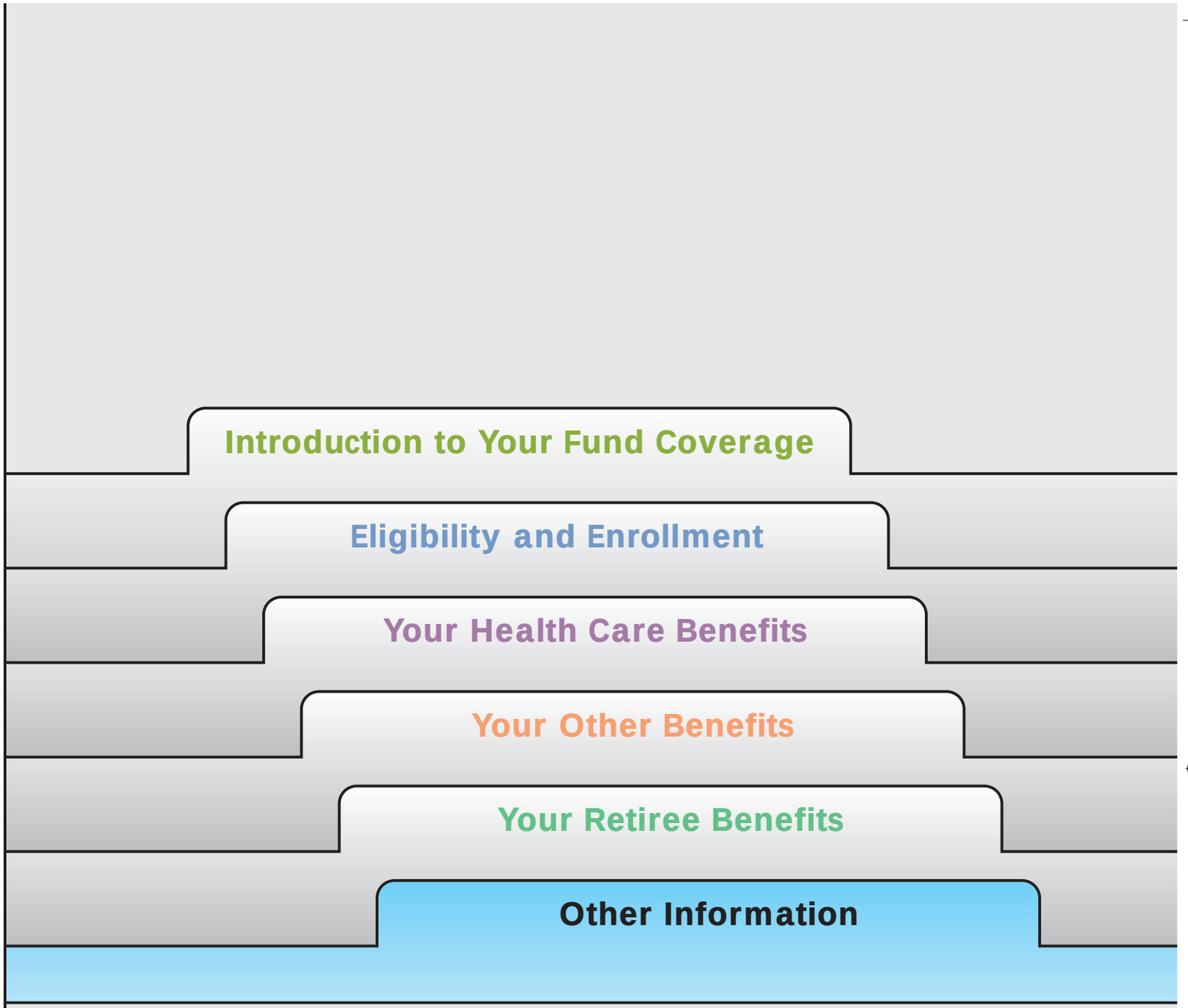
If you elect the Direct Pay Plan and pay the monthly premiums for the same Wage Class benefits that you were eligible for immediately prior to retirement, you will continue to receive the same medical coverage until you become age 65. **However, if there is a change in Fund benefits for active participants, this change will also apply to Direct Pay retirees**.

Right to Elect a Lesser Benefit

You have the option to elect the lesser benefits of a lower Wage Class.

For example, if you had Wage Class I benefits before you retired early, you may choose Wage Class II benefits when you elect Direct Pay coverage. However, you do **not** have the option to elect benefits from a higher Wage Class.

Keep in mind that if you choose a lesser benefit without the prescription drug plan, when you become eligible for the Medicare Supplement Plan you will not be eligible for prescription drug coverage.


Introduction to Your Fund Coverage
Eligibility and Enrollment
Your Health Care Benefits
Your Other Benefits
Your Retiree Benefits
Other Information

HOW CLAIMS ARE FILED

This section provides you with step-by-step instructions on how you file a claim for benefits, outlines your Explanation of Benefits (EOB) and explains the claims review and appeal process. If you have any questions call the Fund Office.

Network Provider Claims Procedure

When you use a Network provider you do not have to file a claim form. You just show your Medical, Prescription Drug or Dental ID Card so that the Network provider knows to bill the Fund.

Highlights

When you use an Out-of-Network provider you may have to pay the bill in full before the Fund reimburses you for the Fund's share of the cost.

Out-of-Network Provider Claims Procedure

When you use an Out-of-Network provider there is no claim form for you to file. However, the provider may choose to:

- bill the Fund, or
- bill you directly

If the provider agrees to bill the Fund, the Fund will pay the provider for the Fund's share of the cost of covered services. You will then be billed for your share of the cost.

If the provider bills you directly, you may have to pay the provider for the full amount. After you pay the Out-of-Network provider, you must send the itemized bill to the Fund Office for any reimbursement. To be considered for reimbursement, the itemized bill must contain the following information:

- your (the participant's) name and Fund ID number
- the patient's name and date of birth
- the date of service
- the provider's name and tax ID number
- the procedure code and diagnosis
- the amount charged for each service, and
- information about other health care coverage you may have under another plan (see the *Coordination of Benefits* section, page 111)

When claim forms are required or you need to send the itemized bill to the Fund for reimbursement, please follow the procedures outlined below:

◆ Prescription Drug Claims

Retail Pharmacy: If you use a non-participating pharmacy, you will have to:

- ❖ pay for the **full amount** of your prescription when it is filled
- ❖ call the Fund Office for a Prescription Drug Claim Form, and
- ❖ complete the Prescription Drug Claim Form and return it to Prescription Solutions, along with a copy of your itemized paid receipt from the pharmacy

Once the claim is received, you will be reimbursed for the Fund's share of the cost of the medication minus the co-pay amount.

◆ Dental Claims

An Out-of-Network provider may require full payment from you at the time of service or may bill you for payment. If you are billed and pay the Out-of-Network provider, you have to submit a claim for reimbursement of covered charges.

Most Out-of-Network dentists will submit a claim form directly to Delta Dental for you. Delta Dental accepts any claim form from an Out-of-Network dentist.

If an Out-of-Network dentist requires you to submit the claim form, you can get a claim form:

- ❖ through the Delta Dental website, www.DeltaDentalnj.com or
- ❖ by calling Delta Dental, toll-free, at 1-800-452-9310

Once the claim is processed, you will be reimbursed by Delta Dental up to the maximum Fund benefit.

◆ Vision Claims

If you use an Out-of-Network provider, you may be required to pay the full amount of your vision care services and supplies at the time of service. If you are billed and pay the Out-of-Network provider, you have to submit a claim for reimbursement of covered charges.

You can get a Vision Care Claim Form by either:

- ❖ calling Davis Vision, toll-free, at 1-800-999-5431, or
- ❖ visiting the Davis Vision website at www.DavisVision.com

Complete the Vision Care Claim Form and return it, along with a copy of your itemized paid receipt from the provider and any other required documentation, to:

Vision Care Processing Unit
P.O. Box 2270
Schenectady, NY 12301

Once the claim is processed, you will be reimbursed by Davis Vision up to the maximum Fund benefit.

Explanation of Benefits

Important Term

When you or a covered family member receives medical services and a claim for that service has been processed, an **Explanation of Benefits Statement** (EOB) is sent to you. The EOB explains the action taken by the Fund on that claim and lists key information about your claim.

An EOB is not a bill. If you are billed for a service for more than the "Patient Should Pay Provider" amount listed on the EOB, you should ask your health care provider for a detailed explanation and call the Fund if you still have questions.

Right to Appeal

If your claim is denied, in whole or in part, you or your representative may appeal the denial by writing to the Fund within 180 days from receipt of your EOB. Your appeal and any additional documentation should be sent to the Fund Office. The factors relied upon in adjudicating the claim are available to you free of charge upon your request. If you do not request a review within 180 days, the denial is final. For more information see the *Claim Review and Appeal Procedures* section, page 109. The Trustees have the sole authority to determine eligibility for benefits and to interpret and apply the terms of the plan.

If you have any questions regarding an EOB contact the Fund Office. You should save your EOBs for tax purposes, as well as for a record of health care services provided to you and your eligible dependents.

Filing a Claim for Accident, Short-term Disability or Life Insurance Benefits

Accident Claims

If your claim for medical, short-term disability or AD&D benefits is related to a diagnosis that may be the result of an accident, the Fund will mail you additional forms. These forms must be completed and returned to the Fund Office before your claim can be processed.

Short-term Disability Claims

To file a claim for short-term disability benefits, you must:

- obtain a Short-term Disability Claim Form from the Fund Office
- complete the Short-term Disability Claim Form and have it filled out by your employer and physician, and
- return it to the Fund, along with a copy of any required documentation

If you have a claim for short-term disability that is related to a contested Workers' Compensation claim, a copy of Form 43 Notice to Contest from Workers' Compensation will be required by the Fund before processing your claim. Once the claim is received, your eligibility for benefits, benefit amounts and duration of benefits will be determined.

Life Insurance Claims

If you die while a participant in the Fund, your beneficiary(ies) should contact the Fund Office. Upon notification, the Fund will process the claim and pay your life insurance benefit to your named beneficiary(ies).

Claims Filing Deadlines

All claims must be submitted according to the following schedule. Claims that are submitted beyond the claims submittal deadline are not eligible for payment.

- ✔ **Claims for Medical Benefits** — Claims for all medical, prescription drug, dental and vision benefits must be received by the Fund Office **within one year** of the date of service for the claim to be considered for payment.

- ✔ **Claims for Short-term Disability Benefits** — Claims for short-term disability benefits must be received by the Fund Office **within one year** of the beginning of the period of disability for the claim to be considered for payment.

- ✔ **Claims for AD&D and Life Insurance Benefits** — Claims for AD&D and life insurance benefits must be received by the Fund Office **within one year** of the date of accident/death to be considered for payment.

Fraudulent Claim

Any person who knowingly files or assists anyone else in filing a claim that contains any material false information or conceals, for the purpose of misleading, information concerning any fact material to the claim commits an act of fraud, which is a crime.

If a fraudulent claim is filed, the Fund will take the following actions:

- the claim will be denied
- full legal sanctions will be pursued, and
- the eligibility of those persons involved in filing the claim will be terminated from Fund coverage for a minimum period of one year, with reinstatement subject to review and approval by the Trustees

If the Fund makes payment on a fraudulent claim or as a result of fraudulent information provided as part of the claims process:

- full legal sanctions will be pursued
- the amount of any claim paid will be recovered, together with interest, and
- the eligibility of those persons involved in filing the claim will be terminated from Fund coverage for a minimum period of one year, with reinstatement subject to review and approval by the Trustees

Denial of Benefits

If your claim for benefits is denied, in part or in whole, you have the right to appeal the denial. For more information about your rights to appeal, see the *Claim Review and Appeal Procedures* section, page 109.

CLAIM REVIEW AND APPEAL PROCEDURES

Important Term

As required by federal law, the Employee Retirement Income Security Act of 1974 (ERISA), the Fund adheres to the following deadlines for initial claim decisions and appeals of denied claims:

FUND DEADLINES FOR INITIAL MEDICAL, DENTAL AND PRESCRIPTION DRUG CLAIM DECISIONS	FUND DEADLINES FOR APPEAL OF DENIED MEDICAL, DENTAL AND PRESCRIPTION DRUG CLAIMS
72 hours for urgent care claims	within 72 hours for urgent care claims
15 days for pre-service claims	30 days for pre-service claims
30 days for post-service claims	60 days for post-service claims
The Fund is allowed one 15-day extension for pre- and post-service claims	The Fund is allowed one 15-day extension for pre- and post-service claims

INITIAL DISABILITY CLAIM DECISION DEADLINES	DISABILITY CLAIMS APPEALS DEADLINES
45 days from receipt of claim	45 days from receipt of the appeal
The Fund is allowed two 30-day extensions	The Fund is allowed one 45-day extension

OTHER INITIAL CLAIMS DEADLINES	OTHER CLAIMS APPEALS DEADLINES
90 days from receipt of claim	60 days from receipt of the appeal
The Fund is allowed one 90-day extension	The Fund is allowed one 60-day extension

Review of Medical Claim Appeal

If you are not satisfied with the reason(s) why your claim was denied or your benefits were reduced, you may appeal to the Board of Trustees. You have 180 days for medical and short-term disability claims and 60 days for other claims to submit a written appeal to the Trustees after you receive the Fund's initial denial of a claim.

Appeals will be reviewed as follows:

1. An independent review will be made of the facts and conclusions used as part of the initial denial of a claim. The review will be conducted by the Fund's Trustee Appeals Committee or the Board of Trustees, neither of which were involved in the initial denial of the claim.
2. When the denial of a claim is based on medical judgment, the Fund's Trustee Appeals Committee may consult a health care professional who has appropriate training and experience in the field of medicine involved.
3. If a health care professional was consulted in connection with the Fund Office's initial denial of a claim, the Trustees will not consult with the same professional in connection with the appeal.
4. Medical or vocational experts whose advice is obtained on behalf of the Fund's Trustee Appeals Committee will be identified.

Appeals will be decided by the Board of Trustees based on the written record, with no personal appearances permitted.

Relevant Documents

You will have the opportunity to submit written comments, documents, records and other information related to your claim for benefits. You will also be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. The review of your appeal will take into account all comments, documents, records and other information submitted without regard to whether such information was submitted or considered in the initial benefit determination.

A full description of the Fund's Claims and Appeals procedures is furnished without charge and accompanies this summary plan description booklet.

SPECIAL SITUATIONS

How Your Benefits Work

Coordination of Benefits (COB)

If You or Other Covered Family Members Have Health Care Coverage Under Another Plan

Important Term

Frequently, members of a family have health care coverage in addition to the benefits provided by the Fund. In such cases, the amount of benefits payable by the Fund will take into account any coverage you or a family member has under another group health plan so that the **combined benefits** under the Fund and the other group health plan will not be more than the amount of the claim. This is known as **coordination of benefits**.

How Coordination Works

The Fund has specific rules regarding the coordination of benefits.

- the primary plan pays first, and the secondary plan pays second:
  - the primary plan pays the maximum amount for benefits under the terms of the primary plan, and
  - the secondary plan pays the difference up to the total amount of allowed expenses, not to exceed the maximum benefits under the terms of the secondary plan

When the Fund is the primary plan, the Fund will pay the benefits described in this booklet. No plan will pay more than it would have paid without this coordination provision.

Which Plan Is Primary and Which Plan Is Secondary?

In order to pay claims, the Fund must determine which plan is primary and which plan is secondary. A plan is primary — in other words, pays claims first — if the plan:

- has no coordination of benefits provision, or
- covers the person as an employee/participant

Dependent Children Who Are Covered by Both Parents' Group Health Plans

In the case of dependent children who are covered by both parents' group health plans, the Fund uses the Birthday Rule to determine which plan is primary for the dependent child.

Under the Birthday Rule:

- the primary plan for the child is the plan that covers the parent whose birthday occurs **earlier** in a calendar year, and
- the secondary plan for the child is the plan that covers the parent whose birthday occurs **later** in the calendar year

For dependent children who are covered under the plans of divorced or legally separated parents or parents separated for more than one year, the plan of the parent who has custody is primary and will pay benefits first and the plan of the parent without custody is secondary for payment.

If there is a qualified divorce decree giving one parent financial responsibility for the medical, dental or other health care expenses of the dependent children, the plan of this parent will be primary and pay benefits first. If none of the above rules applies, the primary plan will be the plan that became effective first.

If Both Wife and Husband Work for a Fund Participating Employer

If a husband and wife are both covered as eligible employees by the Fund, benefits will be provided for both persons and their eligible dependent children on the same coordinated basis as if two separate plans were involved.

Filing a Claim When You or a Family Member Has Other Coverage

You must report all available group health coverage when filing a claim with the Fund. If you fail to tell the Fund about information regarding other plans, your claims may be considered fraudulent claims and you may be disqualified from receiving benefits from the Fund.

The following information is needed in order to coordinate benefits between the primary and secondary plans:

- the type of coverage — single or family
- the name of the plan
- the policy and group number
- the effective date of coverage, and
- a copy of the other plan's ID card (front and back)

Claims should be submitted to the primary plan first. After you have received payment from the primary plan, you should send the itemized bill, along with the Explanation of Benefits Statement (EOB) from the primary plan to the secondary plan for processing.

When Claims Are Rejected by the Primary Plan

When claims for a covered service under the primary plan are rejected because the claimant failed to follow the rules of the primary plan, the Fund, if it is the secondary plan, will not pay the claims.

For example, if the primary plan requires a referral to see a doctor and you do not get authorization for the service and your claim is rejected because you did not follow the primary plan's rules, the Fund will not pay the claim.

When Coverage Ends with the Other Health Plan

If you are covered by the Fund and you terminate coverage with the other health plan or the other health plan terminates your coverage, you must provide the Fund with the termination letter from the health plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

If You Have Dependent Children From a Prior Marriage or Relationship

Medical Child Support Order

Important Term

A 1993 amendment to the Employee Retirement Income Security Act (ERISA) requires the Fund to extend health care coverage to the children of a Fund participant who is divorced, separated or never married when ordered to do so by state authorities. Generally, a state court or agency may require the Fund to provide health benefits coverage to children by issuing a **medical child support order**.

Requirements for Qualification

The Fund must determine whether the medical child support order is qualified.

A Qualified Medical Child Support Order (QMCSO):

- recognizes the right of an "Alternate Recipient" to receive benefits for which a participant is eligible from the Fund or assigns to an Alternate Recipient the right of a participant to receive benefits from the Fund, and
- is recognized by the Fund as "qualified" because it includes information and meets other requirements of the QMCSO provisions

An "Alternate Recipient" is any child of a participant in the Fund who is recognized under a medical child support order as having a right to enrollment in the Fund as an Alternate Recipient. An Alternate Recipient may be terminated from coverage under the same terms and conditions as those that apply to any other covered dependent. For example, in the case of an Alternate Recipient who elects COBRA coverage upon your termination from covered employment, lay-off or death, when COBRA benefits end the Fund is not obligated to provide extended coverage.

A medical child support order must also contain the following information in order to be qualified:

- the name and last known mailing address of the participant and each Alternate Recipient, or the mailing address of a state or local official
- a reasonable description of the type of health coverage to be provided to each Alternate Recipient — or the manner in which such coverage is to be determined
- the period to which the order applies, and
- each plan to which such order applies

An order may not require the Fund to provide any type or form of benefit or any option not otherwise provided by the Fund, except to the extent necessary to meet the requirements of any state laws relating to medical child support orders that the Fund must comply with.

Qualification Procedure

The following steps summarize how the Fund determines if a medical child support order is qualified:

1. When the Fund receives a medical child support order, the Fund will notify you and each Alternate Recipient under the order that the order has been received and supply each with a copy of this procedure.
2. The Fund will, within a reasonable period of time, review the medical child support order to determine whether the document satisfies the minimum requirements for qualification. For example, an order that is clear and complete when submitted should require less time to review than one that is incomplete or unclear. The Fund will notify you and each Alternate Recipient of the Fund's determination.
3. If any party is dissatisfied with the Fund's determination, a written request for review of the decision can be made. A determination by the Fund of the status of the document as a medical child support order and/or whether any medical child support orders submitted are "qualified" will become final in the absence of a written appeal postmarked not later than 90 days after the date on the Fund's determination notice. Upon receipt of an appeal, the Fund will issue a decision within 60 days.
4. Any Alternate Recipient who desires to designate a representative for receipt of copies of notices and determinations that are sent by the Fund can do so by filing a written notification with the Fund of the name and address of the representative.

Payment of Reimbursable Expenses

The Fund must act in accordance with the provisions of the QMCSO as if it were part of the Fund plan. In particular, any payment for benefits as reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian must be made to the Alternate Recipient or custodial parent or legal guardian.

ACCIDENT CLAIMS

If You Are Injured in an Accident

Subrogation and Reimbursement

If you or your dependent is injured in an accident for which someone else may be liable, that person or her/his insurance may be responsible for paying your related medical and disability expenses. These expenses are **not** covered by the Fund. However, waiting for a third party to pay for these injuries and claims may take a long time — you may have to go to court — and your creditors may not wait patiently. As a service to you and your dependents, the Fund will provide advance payment of benefits until the resolution of claims against liable third parties.

! Important Term

These advance payments of benefits are based on the Fund's rights of **subrogation and reimbursement**. Under this provision, you must reimburse the Fund if you obtain any recovery from any person or entity.

You have to exhaust any applicable "no fault" automobile insurance medical benefits and Med Pay before the Fund will pay any amount on related accident claims.

What Is Subrogation?

Subrogation is a legal doctrine that permits the substitution of one person in the place of another with reference to a lawful claim for damages.

Under the Fund's accident claim policy, the Fund takes the place of you or other covered dependents who have a claim against any liable third party in order to get reimbursement by the third party who is liable for your or your covered dependent's injury. This means that when the Fund takes on the responsibility for paying for covered expenses incurred as a result of accidental injury, it acquires the right to be reimbursed from any damages you or your covered dependents subsequently recover from any liable third party.

If you or your covered dependents receive any benefit payments from the Fund, including short-term disability payments, for an injury or illness and you or your dependents recover **any** amount from **any** third party or parties in connection with such injury or illness, you or your dependent must reimburse the Fund from that recovery for the benefit payments the Fund made or will make on your or your dependent's behalf in connection with that injury or illness.

Notification Requirements

You and/or your dependents are required to notify the Fund within 10 days of any accident or injury for which someone else may be liable. In addition, you must notify the Fund:

- within 10 days of the initiation of any lawsuit arising out of the accident
- prior to the conclusion of any settlement, judgment or payment relating to the accident

The Fund's Rights

If you or your dependent(s) receive any benefit payments from the Fund for any injury or illness, the Fund is subrogated to all rights of recovery available to you or your dependents arising out of any claim, demand, cause of action or right to recovery that has accrued, may accrue or that is asserted in connection with such injury or illness, to the extent of any and all related benefit payments made or to be made by the Fund on you or your dependent's behalf.

Simply put, this means that the Fund has an independent right to bring an action in connection with such injury or illness in your or your dependent's name in order to recover benefits paid by the Fund. The Fund also has a right to intervene in any such action brought by you or your dependent, including any action against an insurance carrier under any uninsured or underinsured motor vehicle policy.

In most cases, the Fund does not initiate litigation in your name and does not intervene in your lawsuit against the third party. Rather, the Fund monitors your recovery efforts and must be repaid when you obtain a recovery from the third party, whether before or after filing a lawsuit.

The Fund's rights of subrogation and reimbursement apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the injury or illness, and regardless of whether you or your dependent actually obtains the full amount of such judgment, award, settlement, compromise, insurance or order.

The Fund's rights of subrogation and reimbursement provide the Fund with a first priority lien to any and all recovery in connection with the injury and illness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes, but is not limited to:

- amounts payable under you or your dependent's own uninsured motorist insurance
- underinsured motorist insurance, or
- any medical or no-fault benefits payable

The "make whole" doctrine does not apply to the Fund's rights of subrogation and reimbursement.

The Fund shall have a lien on any amount received by you, your dependent or a representative of you or your dependent — including an attorney — for an amount sufficient to satisfy the Fund's lien. The portion of the money sufficient to satisfy the Fund's lien shall be deemed to be held in trust by you, your dependent or representative for the benefit of the Fund until paid to the Fund.

Accident Claims Where a Third Party May Be Liable

Consistent with the Fund's rights outlined in this section, if you or your dependent submits claims for or receives any benefit payments from the Fund for an injury or illness that may give rise to a claim against any third party, you and/or your dependent will be required to execute accident claim documents affirming the Fund's rights of subrogation and reimbursement with respect to such benefit payments and claims. The accident claim documents must also be executed by your or your dependent's attorney, if applicable.

Return Completed Accident Claim Documents Promptly to the Fund

Since claims related to an injury or illness for which a third party may be liable are not covered expenses under the Fund's plan, those claims will initially be denied by the Fund Office. Upon denial of the claim(s), you will be sent an accident claim questionnaire that you must promptly complete and return to the Fund Office. The Fund Office will review the claims based on your completed accident claim questionnaire and will provide you with the required additional accident claim documents that will enable the Fund Office to process accident-related medical and disability benefits pending resolution of third party liability issues. In order for the Fund Office to consider the payment of benefits related to accidental injury or illness, all required accident claim documents must be fully executed and returned to the Fund Office within six months of the date of injury.

Cooperation with the Fund

Under this provision, you and/or your dependents are obligated to take all necessary action and cooperate fully with the Fund in the exercise of its rights of subrogation and reimbursement, including:

- notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier, and
- notifying the Fund of your or your dependent's pending recovery before entering into a settlement

In addition, you and/or your dependent must do nothing to impair or prejudice the Fund's rights. For example, if you or your dependents choose not to pursue the liability of a third party, you or your dependents may not waive any rights covering any conditions under which any recovery by you or the Fund could be received. If you are asked to do so, you must contact the Fund Office immediately.

Should you or your dependents choose not to pursue the liability of a third party, the acceptance of benefit payments from the Fund:

- authorizes the Fund to litigate or settle its claims against the third party, and
- obligates you, your dependents and your attorney to cooperate with the Fund in seeking amounts paid by the Fund, and in providing relevant information with respect to the accident

Payment from a Third Party

You, your dependents and your attorney must notify the Fund **before** accepting any payment prior to the initiation of a lawsuit. If you do not notify the Fund and you accept payment that is less than the full amount of benefits that the Fund has advanced to you, you may still be required to repay the Fund.

The Fund may withhold benefits if you or your dependents waive any of the Fund's rights to recovery or fail to cooperate with the Fund in any respect regarding the Fund's subrogation rights.

Rights of Recovery

If you or your dependents fail to reimburse the Fund from any recovery from a third party or refuse to cooperate with the Fund regarding its rights of subrogation and reimbursement, the Fund will seek to recover the full amount of all benefits paid to you by means that include, but are not limited to, offsetting the amounts paid against your future benefit payments by the Fund.

Failure or refusal to cooperate with the Fund includes:

- the failure of any party to complete and submit any requested accident claim documents, and
- the failure of any party to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's rights of subrogation and reimbursement

WORKERS' COMPENSATION

If You Are Injured at Work or Suffer From a Work-related Illness

Important Term

If you are injured at work or suffer a work-related illness, you are covered by **Workers' Compensation** laws. The Fund does not pay for any work-related injury or illness claims even if the Workers' Compensation claim is being contested.

Filing a Workers' Compensation Claim

If you suffer a work-related injury or illness, you must file a Workers' Compensation claim. If you don't, you will jeopardize your rights to Workers' Compensation benefits and your benefits from the Fund for yourself and your eligible dependents.

Continuation of Fund Benefits

The Fund will continue to cover you and your eligible dependents for benefits **not** related to the job injury or illness while you are receiving Workers' Compensation benefits if contributions to the Fund continue to be made on your behalf by your employer.

The Fund will also advance weekly short-term disability benefits if your claim is contested by your employer's insurance carrier and is pending before the Workers' Compensation Commission. The Fund will recover those advances from any Workers' Compensation recovery.

If your employer does not continue to make contributions to the Fund on your behalf while you are unable to work, your coverage under the Fund will end. However, you and your eligible dependents can continue to receive medical benefits under COBRA continuation coverage. For more information see the *COBRA* section, page 129.

Employer Contributions on Your Behalf

The Fund provides non-work related benefit coverage for you and your eligible dependents while you are on Workers' Compensation status and unable to work if your employer makes contributions to the Fund on your behalf and on behalf of all of your co-workers on Workers' Compensation status.

If your employer is contesting liability for an injury for which you have filed a claim under Workers' Compensation, the Fund will not pay medical claims related to the injury. If any claims for benefits are paid in error, including short-term disability payments, the Fund shall have a lien on the proceeds of any award or settlement up to the amount of benefits paid by the Fund.

Notifying the Fund

You must inform the Fund Office **immediately** of the date you stopped work due to a work-related illness or injury.

Upon notification, the Fund determines your eligibility for benefits based on wage reports it receives from your employer. If you haven't received any wages and fail to notify the Fund, your coverage may be terminated because the Fund does not know that you are out on Workers' Compensation leave.

Call the Fund Office to find out which forms need to be filed with the Fund.

SPECIAL DEPENDENT COVERAGE RULES FOR 19- TO 22-YEAR-OLD STUDENTS

Your dependent child, between the age of 19 to the day she/he turns 23, continues Fund eligibility as long as:

- you remain eligible for dependent coverage, based on your average hours worked, **and**
- the child meets **all** of the following conditions:
  - is unmarried
  - is dependent upon you for financial support
  - is attending high school or college on a full-time basis, **and**
  - has filed a full-time Student Verification letter with the Fund Office upon turning age 19 and files updated letters twice a year until the child turns age 23

For general eligibility rules for your minor children, see the *Your Minor Children* section, page 13.

Full-time Student Verification Letter

Important Term

When an eligible dependent becomes 19 years old, her/his coverage under the Fund's medical benefits will end unless a **full-time Student Verification letter** has been submitted. The full-time Student Verification letter must contain the following information, based on the type of school the student attends:

High School

The high school Student Verification letter for students over age 19, obtained from the guidance counselor or the principal's office of the high school, must be written on the school's stationary and include:

- the student's attendance dates
- confirmation of full-time student status, and
- the year of expected graduation

Your child must submit a full-time Student Verification letter to the Fund **once a year** with your name and Fund ID number.

College

The college Student Verification letter is obtained from the college or university Registrar's Office and must include:

- the semester dates of attendance
- confirmation of full-time student status — 12 or more credits per semester
- year of expected graduation, and
- the official school seal

Your child must submit a Student Verification letter to the Fund with your name and Fund ID number:

- upon entering her/his freshmen year, and
- **twice a year** — once for the Fall (due September 1st) and once for the Spring (due February 1st) semesters — until reaching age 23

If your child submits a Student Verification letter and your child has not reached age 23, health care benefits for the Fall semester are extended through January 31 and health care benefits for the Spring semester are extended through August 31.

Submit the Student Verification letter to the Fund as soon as possible because your child will not be eligible for health care benefits until the Fund receives the Student Verification letter for the current semester.

For the Student Verification letter to be considered valid, the school must be an accredited high school, college, university or technical school — not a certificate program. A copy of your child's schedule of classes or tuition bill is not a sufficient form of verification.

Notification of Change in Status

It is your responsibility to call the Fund Office when your full-time student, dependent child has:

- reached age 19 and is not enrolled full-time in school
- reached age 23, whether or not in school
- become financially independent, or
- married

When your dependent child is no longer eligible for Fund coverage, the Fund will send your child a COBRA notification, which will allow the dependent to extend her/his health care coverage under the Fund for up to 36 months on a self-pay basis. For more information, see the *COBRA* section, page 129.

CONTINUATION OF COVERAGE

If You Are Laid Off or Your Facility Closes

If you lose your job due to a layoff or facility closing, you and your eligible dependents will remain eligible for coverage by the Fund from the date of layoff or facility closing for a period of 60 days, provided you have a minimum of three consecutive years of Fund participation as of your last day worked.

After the 60-day period has ended, you and your covered dependents may be eligible for continuation of health care benefits under COBRA. For more information, see the *COBRA* section, page 129.

Family Medical Leave Act (FMLA)

Continuation of Coverage If You Take a Qualified Family Medical Leave

Important Term

The Family Medical Leave Act (FMLA) is a federal law that requires employers to provide their employees who satisfy certain qualifying reasons and length of service and hours worked conditions with up to 12 weeks of unpaid FMLA leave in each 12-month period.

The qualifying reasons for an employer-authorized FMLA leave include:

- **medical leave —** a serious health condition that prevents you from performing your job
- **family leave —** you are caring for a seriously ill child, spouse or parent
- **childbirth or newborn care leave —** you are caring for your newborn child up to age one year
- **adoption or foster placement leave —** you are having a child placed with you for adoption or foster care

Use of FMLA Leave

The 12 weeks of FMLA leave may be taken:

- all at once or intermittently for any of the above reasons, or
- at different times for different reasons, including a part-time work schedule if medically necessary due to your health condition or that of a family member

Continuation of Coverage

During a qualified FMLA leave, your employer is obligated to maintain the level of health benefits coverage you had when your FMLA leave began — including prescription drug, dental care and vision care —as if you had continued to work your regular work schedule.

In addition to FMLA, under federal law the Fund will continue to provide coverage for any authorized family leave either under state FMLA law or employer practice for which the employer makes contributions to the Fund.

FMLA and Fund Coverage

If You Qualify for the Fund's Short-term Weekly Disability Benefit

If you have a medical condition, including childbirth leave, that prevents you from working and you qualify for the Fund's short-term weekly disability benefit, your health benefits will be continued during the period that you are receiving weekly disability payments from the Fund, at no cost to you and no additional cost to your employer.

FMLA Non-Disability (Family Leave, Newborn Care Leave, Adoption Leave and Foster Replacement Leave)

The Fund does not provide continued health coverage for non-disabled employees who take FMLA leave for family leave, newborn care leave or adoption leave **unless** your employer has contracted with the Fund to satisfy its FMLA obligation to maintain health benefits during their employees' non-disability approved FMLA leave. Contributing employers are not required to meet this FMLA obligation through the Fund; the employer may elect, for example, to purchase its own health insurance policy for its employees on non-disability FMLA leave that mirrors Fund coverage. In such cases, you will submit all medical, dental, vision, etc., claims directly to your employer for processing and payment.

Contributing employers who elect to contract with the Fund to satisfy their FMLA non-disability obligations to their employees (to maintain the same level of health benefits as they had at the start of their FMLA leave) are required to:

- report all bargaining unit FMLA leaves to the Fund on a timely basis, and
- make contributions to the Fund for the (non-disability) FMLA leave period based on the employee's average gross earnings for the preceding 13-week period and the contribution rate specified in the Union contract

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

Your Health Care Coverage if You Enter Military Service

Continuation of Health Care Coverage

Important Term

If you leave your job to perform military service, you have the right to elect to **continue your existing health care coverage** under the Fund for you and your eligible dependents for up to 24 months while in the military.

This right applies only if you are an active Fund participant and your eligible dependents were covered by the Fund immediately prior to your uniformed leave of absence.

Cost of Continued Health Care Coverage

If you elect to continue your existing health plan coverage, you will be required to pay an amount not more than 102% of the full premium cost of coverage by the Fund.

Period of Continued Health Care Coverage

The maximum length of continuation coverage required under USERRA is the lesser of:

- 24 months — beginning on the day that the uniformed service leave begins, or
- a period beginning on the day that the uniformed service leave began and ending on the day after you fail to return to employment within the time allowed by USERRA

Reinstatement of Health Care Coverage

Even if you do not elect to continue your health care coverage during your military service, you and your eligible dependents have the right to be reinstated to Fund coverage if, upon honorable discharge, you return to active covered employment with a contributing Fund employer.

An exclusion or waiting period may **not** be imposed except for military service-connected illnesses or injuries.

WHEN YOUR BENEFITS END

If any of the following situations occurs, you will be notified and you and your eligible dependents will be offered COBRA continuation health care coverage, except as otherwise noted.

1. **You are no longer employed** by a contributing employer, or your employer is not obligated to make payments to the Fund on your behalf.

   If either event occurs, your eligibility under the Fund will end on the **last day of the last month** in which your employer is obligated to make a contribution payment on your behalf.

Example

Jane Doe terminates her covered employment in July 2007.

Since her employer's August 2007 payment is based on July 2007 payroll including her July earnings, she may be eligible, depending on her July earnings, for benefits under the Fund until **August 31,** 2007.

2. **Your employer fails to make required contributions** on a timely basis on your behalf. When your employer fails to make timely required contributions, your eligibility under the Fund ends on the **last day of the month** in which there are no employer contributions.

Example

Employer A's last contribution is received as due in July 2007, which provides benefit coverage for August 2007.

If Employer A fails to make the required August 2007 contribution payment by August 31, 2007 — payment is required by the last business day of the month — the last day Employer A's employees will be eligible for benefits is August 31, 2007.

   In this case, you remain ineligible — until your employer becomes current with the Fund or enters into a repayment schedule that is accepted by the Fund — and you will be sent a COBRA notice.

3. **Your Short-term Disability Benefits End**
   When you are receiving short-term disability from the Fund, the Fund extends your eligibility for all benefits you qualified for at the onset of your disability, up to a maximum of 26 weeks in a 52-week period. If you do not return to work after your physician has said you are able to return to work, or if you have exhausted the 26 weeks of short-term disability and you do not return to work, your Fund eligibility will end and the Fund will offer you COBRA continuation health care coverage.

   For more information, call the Fund Office and see the *Short-term Disability Benefits* (page 77) and *COBRA* (page 129) sections.

4. Your Workers' Compensation Leave Ends
When you are out of work on Workers' Compensation, the Fund does not provide benefit coverage unless your employer makes contributions on your behalf and on behalf of all your co-workers on Workers' Compensation. If your employer has not signed a separate agreement with the Fund or fails to make required contributions, your benefits will end and the Fund will offer you COBRA continuation health care coverage.

For more information, call the Fund Office and see the *Workers' Compensation* section, page 119, and the *COBRA* section, page 129.

Benefits Available After Your Coverage Stops

If your coverage has ended but you have a loss covered under the AD&D Insurance plan, the Fund will pay AD&D benefits according to the schedule of benefits if:

- the loss is due to an accident
- the accident happened while you were covered by the Fund, and
- the loss occurs within **180 days** after the accident

If You Become Totally and Permanently Disabled

If you or an eligible dependent are totally and permanently disabled when coverage stops and remain, totally and permanently disabled from the same cause for the entire time from when the coverage stops until charges are incurred, the Fund will pay for certain charges related to the treatment of the continuing cause of the total and permanent disability.

Total and permanent disability means you or your dependent's complete inability to engage in any occupation or employment for which you are or become qualified by reason of education, training or experience and you are not in fact engaged in any occupation or employment for pay or profit.

What Is Covered

The payable charges are as follows:

- ✔ hospital benefits for a confinement that begins within three months of the time coverage stops, provided the confinement is required by the continuing cause of the total and permanent disability, and
- ✔ other covered charges for health benefits for treatment of the continuing cause of the total and permanent disability incurred within three months of the date coverage stops

The Fund will pay these expenses only if the expenses are not payable under any other health insurance plan.

What Is Not Covered

Charges for the following services are not covered under this provision:

- ⊘ emergency room treatment services
- ⊘ prescription drugs
- ⊘ behavioral health care, and
- ⊘ vision care

WHEN YOU LEAVE COVERED EMPLOYMENT OR RETIRE

If You Want to Continue Your Health Care Coverage

COBRA (Consolidated Omnibus Budget Reconciliation Act)

What Is the COBRA Continuation of Coverage Law?

Important Term

COBRA continuation coverage is a temporary extension of health care coverage under the Fund. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA continuation coverage can become available to you and to other eligible members of your family who are covered by the Fund at the time you lose eligibility for health care coverage under the Fund.

Under federal law, COBRA continuation coverage is not available to civil union partners, same-sex marriage partners or same-sex domestic partners who lose Fund eligibility. However, covered dependent children must be offered COBRA continuation coverage.

In addition, COBRA continuation coverage does **not** apply to the following benefit coverage offered by the Fund:

- life insurance
- AD&D insurance
- short-term disability benefit, and
- scholarship

Who Is Entitled to Benefits Under COBRA?

COBRA continuation coverage is a continuation of Fund coverage when coverage would otherwise end because of a life event known as a "qualifying event." COBRA continuation coverage must be offered to each person who is a "qualified beneficiary."

A qualified beneficiary is someone who will lose coverage under the Fund because of a qualifying event. Depending on the type of qualifying event, you, your spouse and your eligible dependent children may be qualified beneficiaries. **Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.**

1. **If you are an employee who is a participant in the Fund,** you will become a COBRA qualified beneficiary if your eligibility for benefit coverage ends because your hours are reduced or your covered employment is terminated for reasons other than gross misconduct.

2. **If you are the spouse of an employee who is a participant in the Fund,** you will become a COBRA qualified beneficiary if you will lose coverage under the Fund because any of the following qualifying events happens

   a) your spouse dies
   b) your spouse's hours are reduced, resulting in loss or reduction of benefits
   c) your spouse's employment ends for any reason other than gross misconduct
   d) your spouse becomes enrolled in Medicare (Part A, Part B or both), or
   e) you become divorced, legally separated or separated from your spouse for more than one year

3. Your Eligible Dependent Children
Your eligible dependent children become COBRA qualified beneficiaries if they lose coverage under the Fund because any of the following qualifying events happens

a) you, the parent-employee, die
b) your, the parent-employee's, hours of covered employment are reduced, resulting in loss or reduction in benefits
c) your, the parent-employee's, covered employment ends for any reason other than gross misconduct
d) you, the parent-employee, become enrolled in Medicare (Part A, Part B or both)
e) the parents become divorced, legally separated or separated for more than one year
f) the dependent stops being eligible for Fund coverage as a "dependent child"

For the definition of "Dependent Child," see the *Your Minor Children* section, page 13.

4. A child that is born to or placed for adoption with you, the formerly covered employee, during a period of COBRA coverage is a qualified beneficiary. You must give written notice to the Fund Office within 60 days of the birth or adoption of the child while on continuing coverage. The newly added child's maximum COBRA coverage period begins on the date of the qualifying event that created the COBRA coverage during which the child was born or adopted — not the date of the birth or adoption.

5. A qualified beneficiary has the right to elect continuation coverage even if she/he is already covered under another group health plan, including Medicare.

Notification Requirements

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund has been notified that a qualifying event has occurred. Notification requirements are:

You or Your Family Member

You or a family member must notify the Fund Office, **in writing,** within **60 days** of the following qualifying event:

- divorce, legal separation or separation of you and your spouse for more than one year, or
- a dependent child's loss of eligibility for coverage as a dependent child under the Fund

Failure to give written notice within this 60-day period will result in the loss of the affected person's right to elect continuation coverage.

Your Employer

Your employer must notify the Fund Office within **30 days** of the following qualifying events:

- the termination of your covered employment or reduction in hours
- your death, or
- your enrollment in Medicare (Part A, Part B or both)

Electing Continuation Coverage

Once the Fund Office receives notice that a qualifying event has occurred, the appropriate election form will be sent to the qualified beneficiaries within 14 days.

COBRA continuation coverage will be offered to each qualified beneficiary. For each qualified beneficiary who elects COBRA continuation coverage during the appropriate time frame and makes the required payments, COBRA continuation coverage will begin on the date that coverage under the Fund would otherwise have been lost.

Notification/Election Deadlines

30/60 DAYS TO NOTIFY FUND	14 DAYS	60 DAYS TO ELECT COBRA
Your **Employer** has 30 days to tell the Fund of a qualifying event **You and other Qualified Beneficiaries** have 60 days to notify the Fund, in writing, of a qualifying event	The **Fund** will send an election notice to each Qualified Beneficiary within 14 days of notification of a qualifying event	The **Qualified Beneficiary** has 60 days to elect COBRA continuation coverage and send the completed COBRA election form

Right to Elect a Lesser Benefit

Under COBRA, the Fund allows you and other qualified beneficiaries the option to elect a lesser level of benefits from a lower Wage Class. However, you do **not** have the option to elect benefits from a higher Wage Class.

For example, if you are in Wage Class I you may choose Option I through Option IV (in the box below); if you are in Wage Class II you may only choose Option III or Option IV; and if you are in Wage Class III you may only choose Option IV.

COBRA Continuation Coverage Options

WAGE CLASS I	WAGE CLASS II	WAGE CLASS III
Option I — Medical, Major Medical, Hospital, Surgical, Lab and X-Ray, Dental Care, Vision Care and Prescription Drugs benefits Option II — same as above except no Dental or Vision Care benefits	Option III — Medical, Major Medical, Hospital, Surgical, Lab and X-Ray and Vision Care benefits	Option IV — Hospital, Surgical and Vision Care benefits

Highlights

You and other Qualified Beneficiaries have 60 days to notify the Fund, in writing, of a qualifying event.

Cost of Continuation Coverage

When you were an active participant, your employer paid for your coverage by the Fund. Under COBRA, as a former participant no longer receiving benefits, you pay the entire COBRA premium amount. The COBRA rates are calculated annually by the Fund actuary based on the Fund's actual cost experience and are updated February 1, of each year.

The Fund accepts checks or money orders. No credit cards or cash are accepted for payment.

COBRA Payment Time Frame

The initial premium payment must be paid within **45 days** after the date of the COBRA election by the qualified beneficiary. **Your first COBRA payment must cover the period from the date you choose to elect COBRA back to the date Fund eligibility ended due to the qualifying event.**

After you pay the initial COBRA premium payment the Fund will send you a one-time statement, which breaks down the coverage periods and the amount of the premium payments. There is a 30-day grace period for payments. Payment is considered to be made on the date it is sent to the Fund.

The Fund does not send monthly statements. It is your responsibility to send in payments for your COBRA coverage by the first day of each month.

COBRA Payment Time Frame

60 DAYS	45 DAYS	30 DAYS
The Qualified Beneficiary has 60 days to choose COBRA and inform the Fund	The Qualified Beneficiary has 45 days from the date of COBRA election to send the initial premium payment to the Fund. This payment must cover the period from the date the Qualified Beneficiary would have lost coverage through the month the Qualified Beneficiary elected COBRA	**After the initial premium is paid, the Qualified Beneficiary has 30 days to send each current monthly premium to the Fund**

How Long Will COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the termination of the employee's eligibility for benefit coverage, COBRA continuation coverage lasts up to 18 months.

When the qualifying event is the death of the employee; enrollment of the employee in Medicare (Part A, Part B or both); your divorce or legal separation, or separation from your spouse for more than one year; or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

There are two ways in which the 18-month period of COBRA continuation coverage can be extended.

1. **Disability extension of 18-month period of continuation coverage**
   If you or a covered dependent under the Fund is determined by the Social Security Administration to be disabled **at any time during the first 60 days of COBRA continuation coverage** and you notify the Fund Office within the 18-month period, you and your eligible dependents can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months:

   - A qualified beneficiary must be determined, under the Social Security Act, to have been disabled at any time during the first 60 days of COBRA coverage.
   - The determination of disability can be made at any time before the end of the 18-month period (subject to notification rules); however, the actual disability must have existed at any time during the first 60 days of COBRA coverage.
   - If a qualified beneficiary is determined to have been disabled, he or she must notify the Fund **in writing** of the Social Security Administration's determination within 60 days of the determination and before the end of the original 18-month COBRA coverage period.

2. **Second qualifying event extension of 18-month period of continuation coverage**
   If your family experiences another qualifying event while receiving COBRA continuation coverage, your qualified spouse and qualified dependent children can get additional months of COBRA continuation coverage, up to a maximum of 36 months.

   This extension is available to your spouse and dependent children if you:

   - die
   - enroll in Medicare (Part A, Part B or both), or
   - get divorced, legally separated or are separated from your spouse for more than one year

The extension is also available to a dependent child when that child's Fund eligibility ends. In each case, you must notify the Fund Office, in writing, of the second qualifying event within 60 days of the event.

Summary of COBRA Coverage Duration

QUALIFIED BENEFICIARY(IES)	INITIAL QUALIFYING EVENT	PERIOD OF COVERAGE*
You Your spouse Your dependent children	Your employment is terminated (for reasons other than gross misconduct) or your hours are reduced	18 months**
QUALIFIED BENEFICIARY(IES)	**SECOND QUALIFYING EVENT**	**PERIOD OF COVERAGE**
Your spouse Your dependent children	• You are entitled to Medicare • You become divorced, legally separated or separated from your spouse for more than one year • You die	36 months
Dependent child	Loss of dependent child status	36 months
*Coverage begins on the date that coverage would otherwise have been lost by reason of a qualifying event and will end at the end of the maximum period. **This 18-month period may be extended for all qualified beneficiaries if a qualified beneficiary is determined to be disabled for purposes of COBRA.		

Early Termination of COBRA Continuation Coverage

Continuation coverage will be cut short of the allowable coverage period under any of the following conditions:

1. **Late or non-payment of COBRA**
   Payment is due by the first of the month. If the payment for purchasing coverage is not received in the 30-day grace period, your COBRA coverage is terminated and COBRA coverage can not be reinstated. For example, if the COBRA payment is due November 1, and the payment is not received by November 30, your COBRA coverage will be terminated and cannot be reinstated.

2. **Coverage under another employer's group health plan**
   The qualified COBRA beneficiary becomes covered by another employer's group health plan that does not limit or exclude coverage for that qualified beneficiary's pre-existing conditions. If the qualified beneficiary becomes covered by another employer's group health plan and that plan contains a pre-existing condition limitation that affects the qualified beneficiary, the qualified beneficiary's continuation coverage cannot be terminated early as a result of the new group health coverage. However, if the other plan's pre-existing condition rule does not apply to the qualified beneficiary by reason of the Health Insurance Portability and Accountability Act's restrictions on pre-existing condition clauses, the Fund may terminate the qualified beneficiary's COBRA coverage.

3. **You become entitled to Medicare**
   At the date you become entitled to Medicare, your COBRA continuation coverage ends. Any continuation coverage for your qualified spouse or qualified dependent children may be extended up to 36 months, measured from the beginning of your initial 18 months of continuation coverage.

If You Have Questions

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

Notify the Fund of Address Changes

In order to protect your and your family's rights, you should contact the Fund Office and report any change in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund.

Certification of Creditable Coverage

Important Term

When your coverage under the Fund ends, a federal law — the Health Insurance Portability and Accountability Act (HIPAA) — protects you if your new health plan excludes pre-existing conditions.

At the time coverage ends with the Fund for you or a covered dependent, the Fund is required to issue you a Certification of Creditable Coverage. When you or your dependents apply for new coverage, the Certificate of Creditable Coverage will dictate whether or not your new health plan can impose a pre-existing condition exclusion on some or all benefits under the new health plan.

The Certificate of Creditable Coverage includes all information on you or your dependent's former coverage, including the date your creditable coverage ended.

Keep this certificate with your other important papers.

You will automatically receive a "Certificate of Creditable Coverage" when:

- you are entitled to elect COBRA
- your coverage ends, even if you are not entitled to COBRA
- your COBRA continuation coverage ends, and
- on your request, within 24 months after your Fund coverage ends

The certificate does not apply to disability, life insurance, accidental death and dismemberment and loss of sight insurance, scholarship, dental care or vision care benefits.

GENERAL PLAN INFORMATION

Your ERISA Rights

Important Term

As a participant in the Fund, you have certain rights and protections under the **Employee Retirement Income Security Act of 1974 (ERISA).**

Getting Information

You have the right to:

- Examine without charge, at the Fund Office, all documents governing the Fund, including insurance contracts and Union Contracts and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor (DOL) and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration at the DOL.
- Obtain, upon written request to the Fund, copies of documents governing the operation of the Fund, including insurance contracts and Union Contracts and copies of the latest annual report (Form 5500 Series) and the updated summary plan description (SPD). The Fund may make a reasonable charge for the copies.
- A statement that participants and beneficiaries may receive from the Fund, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Fund and, if the employer or employee organization is a Fund sponsor, the sponsor's address.
- Receive a summary of the Fund's annual financial report. The Fund is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for you, your spouse and/or your dependent children if you lose coverage under the Fund as a result of a qualifying event. You and/or your dependents will have to pay for such coverage.

You should review this summary plan description (SPD) and the documents governing the Fund on the rules governing your COBRA continuation coverage rights.

You will be provided a Certificate of Creditable Coverage, free of charge, from the Fund when:

- you lose coverage under the Fund
- you become entitled to elect COBRA continuation coverage
- your COBRA continuation coverage ends, if you request it before losing coverage, or
- if you request it up to 24 months after losing coverage

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in another employer's group health plan.

Fiduciary Responsibility

In addition to creating rights for Fund participants, ERISA imposes duties upon the people who are responsible for the operation of the Fund, called "fiduciaries."

The fiduciaries have a responsibility to operate the Fund prudently and in the interest of all Fund participants and eligible dependents.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcing Your Rights

Under ERISA, there are steps you can take to enforce your rights:

- ✔ If you request a copy of Fund documents to which you are entitled, including the latest annual report from the Fund, and you do not receive them within 30 days, you may file suit in a federal court.
- ✔ If you have a claim for benefits that is entirely or partially denied or ignored, you may file suit in a state or federal court after you have completed the Fund's appeals procedure (see the *Claim Review and Appeal Procedures* section, page 109 and the full description of the Claims and Appeals procedure that accompanies this summary plan description booklet), if you believe that the decision against you is arbitrary and capricious.
- ✔ If you disagree with the Fund's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.
- ✔ If you believe the Fund's fiduciaries have misused the Fund's assets, or if you believe you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about:

- ◆ **Your Fund benefits**, you may call the Fund Office at 1-800-227-4744 or 860-728-1100.
- ◆ **Your rights under ERISA**, or if you need assistance in obtaining documents from the Fund, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor. Addresses and phone numbers of Regional and District EBSA Offices are available in your phone book or through EBSA's website at: www.dol.gov/ebsa
- ◆ The EBSA regional office for Connecticut is:

Boston Regional Office
J.F.K. Building, Room 575
Boston, MA 02203
James Benages - Director
Tel 617-565-9600
Fax 617-565-9666

You may also obtain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration, toll-free, at 1-866-444-EBSA (1-866-444-3272).

PLAN AMENDMENT, MODIFICATION AND TERMINATION

Right to Amend, Modify or Terminate

The Fund Board of Trustees, in its sole and absolute discretion, reserves the right to amend, modify or terminate the benefits offered by the Fund.

It is anticipated that the Fund will remain in effect indefinitely. However, if it ever becomes necessary to terminate the Fund, the Trust Agreement provides that assets then held by the Trustees must be used exclusively on behalf of Fund participants. In no event will any of the assets revert to any employer or to the Union.

In the event of termination of the Fund, the assets are to be used exclusively to continue the payment of benefits provided to eligible participants, their dependents, beneficiaries or their estates to defray reasonable administration and termination expenses and to otherwise effectuate the purpose of the Trust Agreement. Upon the necessity for termination, the Trustees would establish a plan to be applied to the balance of assets so that the assets would be applied solely for these purposes.

Upon final liquidation of the Fund, participants and beneficiaries would have no further rights or vested interest in the Fund.

Important Notice

This summary plan description (SPD) describes the provisions of the Fund as it exists on the date shown on the front cover of this booklet. From time to time these provisions may be amended by the Trustees. To the extent the provisions described in these pages are amended, you will receive updated information in a timely manner.

Required Disclosures

If at any time there is a material reduction in covered services under the Fund, you will be notified through a summary of material modifications (SMM), which will be issued within 60 days following the date that the modification is adopted.

Changes in Fund Benefits

If any Fund benefits are changed, all care you and your eligible dependents receive after the effective date of the change will be subject to the change, even if you and your eligible dependents were receiving care before the change became effective.

Authority of the Plan Administrator

The Fund Trustees — also referred to as the Plan Administrator — are responsible for interpreting and applying Fund provisions and for making final Fund determinations. In order to carry out their responsibilities, the Trustees have exclusive authority and sole discretion to:

- determine whether an individual is eligible for any benefits under the Fund
- determine the amount of benefits, if any, an individual is entitled to from the Fund
- determine or find facts that are relevant to any claim for benefits from the Fund
- interpret all Fund provisions
- interpret all provisions of the SPD
- interpret the provisions of the Trust Agreement governing the operation of the Fund
- interpret any other document or instrument involving or having impact upon the Fund, and
- interpret all of the terms used by the Fund, the SPD and in all of the other previously mentioned agreements, documents and instruments

Because you receive or submit a claim is no guarantee that you are eligible for benefits or that you will receive benefit payment.

Your Welfare Fund

The Fund is a self-administered, labor-management, Taft-Hartley Trust Fund. Your benefits are provided pursuant to a Union Contract between your employer and your union. In most cases, your employer contributions pay for your benefits. Your Union Contract — the collective bargaining agreement between your employer and your Union — requires that your employer make payments to the Fund on your behalf for health care benefits. The Union dues or agency fees you pay to District 1199 cover the cost of running the Union and play no part in covering the cost of providing health benefits.

The Fund is a non-profit organization — all of the money received by the Fund on your behalf goes directly to providing you and your eligible dependents with health care benefits.

The Connecticut Coalition of Taft-Hartley Health Funds

The Fund is a member of the Connecticut Coalition of Taft-Hartley Health Funds (the Coalition). The Fund saves you money by being a member of the Coalition. The Coalition, representing multiple Union-sponsored health funds, is able to consolidate its buying power in order to negotiate more favorable rates with preferred provider organizations (PPOs) such as physicians, hospitals, chiropractic therapy, dental care, hearing care, behavioral health benefits, physical therapy, prescription drug plans and vision care.

Definitions

Self-administered means that the Fund staff is responsible for the day-to-day administration of the Fund, including processing your claims, answering your questions and performing other administrative operations.

Labor-Management means that the Fund is run by an equal number of trustees appointed by the union and by contributing employers.

Taft-Hartley is the name of the federal law that allows labor-management trust funds to be established.

Privacy Notice

At the Fund, protecting the privacy and confidentiality of your personal information is very important to us. In order to provide and administer benefits and services to you, we may collect, use and disclose personal information. To help you better understand our commitment to protect the privacy and confidentiality of this information, we have a Privacy Notice that describes what types of information we collect, the measures we take to safeguard it and the situations in which we might share that information.

If you would like a copy of this notice please call the Fund Office, toll-free, at 1-800-227-4744 or 860-728-1100.

Women and Infants Hospital of Rhode Island Benefit

The Fund's vision care, scholarship, life insurance and accidental death and dismemberment and loss of sight (AD&D) benefits are provided to Women and Infants Hospital eligible employees. See the *Vision Care Benefits* (page 69), *Life Insurance Benefits* (page 83) and *Accidental Death and Dismemberment and Loss of Sight Benefits* (page 89) sections.

These limited benefits are financed by contributions from Women and Infants Hospital. In addition, the Fund provides retiree medical benefits, the Medicare Supplement Plan (including prescription drug coverage) and the Direct Pay Plan for eligible Women and Infants Hospital retirees. Call the Fund Office for more information.

INFORMATION ON YOUR PLAN

The following supplements the information contained elsewhere in this booklet and is provided in accordance with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

Name of Plan and Identification Number

New England Health Care Employees Welfare Fund
Federal Identification Number: 06-1188411
Plan No. 501

Type of Plan

Taft-Hartley (Union-Employer) Jointly Trusteed Employee Welfare Benefit Fund

Plan Administrator

The Fund is administered by a joint Board of Trustees composed of the Union Trustees and the Employer Trustees listed below:

UNION TRUSTEES	EMPLOYER TRUSTEES
Jerome P. Brown	Beth Goldstein — Jewish Home for the Aged
Carmen Boudier	Jerry McCarthy — St. Mary Home
Rosemary Brown	Stuart Rosenberg — St. Francis/Mt. Sinai Hospital
Brenda Morisette	Colleen Scott — Waterbury Hospital
David Pickus	Marilyn Walsh — Women and Infants Hospital
Barbara Stoltman	Vacant as of date of publication of this booklet

The business office address, telephone number and fax number of the Board of Trustees are:

Board of Trustees
New England Health Care Employees Welfare Fund
77 Huyshope Avenue
Hartford, Connecticut 06106-7001

Telephone: **860-728-1100**
Fax: **860-947-8080**

Type of Administration and Method of Funding Benefits

The Fund is administered by a Board of Trustees and the Trustees' decisions in all matters concerning the Fund are final. The Fund provides medical, dental, vision, prescription drug, disability and scholarship benefits to eligible participants and their eligible dependents on a self-insured basis. The Fund also provides accidental death and dismemberment and life insurance benefits through a fully-insured contract with the Union Labor Life Insurance Company (ULLICO).

Name and Address of Agent for Service of Process

Legal papers may be served on the Fund Trustees or the Fund's Counsel:

John M. Creane, Esq.
Attorney at Law
92 Cherry Street
Milford, Connecticut 06460

Actuarial Consultant

Milliman

Certified Public Accountant

Buckley, Frame, Boudreau and Company, P.C.

Executive Director

Robert Tessier

Investment Consultant

The Marco Consulting Group

Investment Manager

Wright Investors Service

Financing of the Plan

Employer contributions to the Fund and job classifications covered are set forth in the District 1199 Union Contracts. Unless you are in a job classification covered by the Union Contracts, contributions cannot legally be made on your behalf, with the exception of certain non-collectively bargained employers.

The employer contributions are received and held in trust by the Board of Trustees for payments of benefits directly from the Fund, payment of insurance premiums, investment of plan assets and payment of Fund administrative expenses.

Fiscal Year

The fiscal year of the Fund is the 12-month period ending each December 31 and the Fund's records are maintained on that basis.

HEALTH CARE TERMS

The following definitions apply when the terms are used in the Summary Plan Description.

Appeals: A process used by a participant to request the Fund Trustees to reconsider a Fund Office claim decision or utilization management decision.

Beneficiary: The person you have named to receive any life insurance or AD&D death benefit.

Benefit: The portion of the costs of covered services paid by the Fund. For example, if the Fund pays 80% of the network-allowed amount of a hospital bill, the amount the Fund pays is the "benefit."

Board of Trustees: The Board of Trustees is established under provisions in the Trust Agreement and is comprised equally of union and management trustees.

Calendar Year: A year beginning on January 1 and ending December 31 of the same year.

Case Management: Coordination of services to help meet a patient's health care needs, usually when the patient has a condition that requires multiple services from multiple providers. This term is also used to refer to coordination of care during and after a hospital stay.

Chiropractic Care: An alternative medicine therapy administered by a licensed chiropractor. The chiropractor adjusts the spine and joints to treat pain and improve general health.

Claim: A request for payment of benefits for health care services provided to a participant.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, which requires that coverage be offered to formerly eligible employees and their eligible dependents at group rates. The participant or eligible dependent must pay for this coverage. See the *COBRA* section, page 129.

Coordination of Benefits (COB): COB applies when you or a covered dependent are covered by two health plans at the same time. COB designates the order in which the health plans are to pay benefits. See the *Coordination of Benefits* section, page 111.

Cosmetic Surgery: Any operative procedure performed primarily to improve physical appearance on an elective basis. The Fund does not cover cosmetic surgery.

Custodial Care: Care that assists the individual in meeting the activities of daily living but does not require professional medical personnel. Examples are homemaking, preparing meals or special diets, acting as a companion or sitter and supervising medication that can usually be self-administered. The Fund does not cover custodial care.

Dentist: A state licensed Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) whose degree is concerned with the healing arts relating to the teeth, oral cavity and associated structures.

Dependent Coverage: If you qualify for the dependent coverage benefit, your eligible dependents become covered on the same day your coverage starts, except if a dependent is already hospitalized on the day your coverage would have become effective. In this case, dependent coverage will not become effective until the dependent is discharged from the hospital. Your eligible dependents may include your spouse, civil union partner, same-sex domestic partner and your eligible children. An ex-spouse is not an eligible dependent, regardless of any agreement, court order or divorce decree.

Durable Medical Equipment: Durable medical equipment is reviewed on a case by case basis by the Fund medical consultant. Durable medical equipment must meet all the following requirements:

- is prescribed by the attending physician
- is medically necessary
- is primarily and customarily used for a medical purpose
- is designed for prolonged use, and
- serves a specific therapeutic purpose in the treatment of an illness or injury

Emergency, Medical

A medical emergency is the sudden and unexpected onset of an illness or an injury that you believe endangers your life or could result in serious injury or disability and requires immediate medical or surgical care.

Employee Retirement Income Security Act of 1973 (ERISA): Federal legislation that applies to retirement programs and to employee welfare benefit programs established or maintained by employers and unions.

Experimental Procedures: Experimental, investigational or unproven procedures and treatments.

Explanation of Benefits (EOB): A form sent to the participant after a claim for payment has been processed by the Fund. The form explains the Fund action taken on that claim. This explanation includes the benefits provided; the allowable reimbursement amounts; any deductibles, co-insurance or other adjustments applied; reasons for denying payment; the net amount paid and the claims appeal process.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A federal law that guarantees renewability and availability of health coverage to certain individuals and limits the exclusion period for pre-existing conditions. HIPAA's Administrative Simplification and Privacy Act final rules took effect in April 2003. The purpose of these rules is to improve the efficiency of the health care system by standardizing the electronic exchange of health information and protecting the security and privacy of participant-identifiable health information.

Home Health Care: Health services rendered in the home to an individual who is confined to the home. Such services are provided to individuals who do not need institutional care, but who need nursing services or therapy, medical supplies and special outpatient services. Services rendered by relatives who are related by blood or marriage or by someone who resides in your home or the home of a dependent are **not** covered. See the *Home Care Services* section, page 57.

Hospice: A health care facility that provides supportive care for the terminally ill.

Hospital: The hospital must be accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations and is approved by Medicare as a hospital.

Level of Benefit: The Wage Classification — Wage Class I, Wage Class II or Wage Class III — used to determine the specific package of benefits for which you and your eligible dependents are entitled.

Medical Child Support Order: a judgment, decree or order — including an approval of a property settlement — that:

- is made pursuant to state domestic relations law — including a community property law — or certain other state laws relating to medical child support, and
- provides for child support or health benefit coverage for a child of a participant under a group health plan and relates to benefits under the plan

Any judgment, decree or order that is issued by a court of competent jurisdiction or an administrative agency authorized to issue child support orders under state law — such as a state child support enforcement agency — and that provides for medical support of a child is a medical child support order. See the *Qualified Medical Child Support Order* section, page 113.

Medical Necessity or Medically Necessary Services: Services or supplies provided by a licensed health facility or health professional, which are determined by the Fund to be:

- Not experimental or investigational
- Appropriate and necessary for the symptoms, diagnosis, or treatment of a condition, illness or injury
- Not primarily for the convenience of the participant or the participant's physician
- The most appropriate supply or level of service that can safely be provided. For example, outpatient rather than inpatient surgery may be authorized when the outpatient setting is safe and adequate.

Medicare: Title XVIII of the Social Security Act, which provides payment for medical and health services to the population aged 65 and over regardless of income, as well as certain disabled persons and persons with End Stage Renal Disease (ESRD).

Medicare Part A: Hospital insurance provided by Medicare that can help pay for inpatient hospital care, medically necessary inpatient care in a skilled nursing facility, home health care, hospice care and end-stage renal disease treatment.

Medicare Part B: Medicare-administered medical insurance that helps pay for certain medically necessary health care provider services, outpatient hospital services and supplies not covered by Part A hospital insurance of Medicare coverage. Doctors' services are covered under Part B even if they're provided to a participant in an inpatient setting. Part B can also pay for some home health services when the beneficiary doesn't qualify for Part A.

Network-allowed Charge: The maximum amount that the Fund recognizes as an eligible expense for the service rendered, as set forth in the Fund's schedule of network-allowed charges.

Network Provider: A health care provider — doctor, clinic, hospital, pharmacy, laboratory and other providers of health care — who has contracted with the Fund or a vendor of the Fund to provide services for Fund participants at reduced fees.

Occupational Therapy: Treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting and bathing.

Out-of-Network Provider: A health care provider — doctor, clinic, hospital, pharmacy, laboratory and other provider of health care — who has **not** contracted with the Fund or a vendor of the Fund to provide services for Fund participants at reduced fees.

Participant: A person who is eligible to receive benefits under the Fund. This term may refer to the employee, spouse or other eligible dependents.

Participating Employer: An employer who is obligated to contribute to the New England Health Care Employees Welfare Fund to pay for employee benefits offered by the Fund.

Participating Pharmacy: A licensed, registered pharmacy that has signed an agreement with the Fund's Prescription Benefit Manager (PBM).

Physical Therapy: Rehabilitation concerned with restoration of function and prevention of physical disability following disease, injury or loss of body part.

Pre-certification: (Also known as Certification, Authorization or Prior Authorization) Certain health care services, such as hospitalization, require pre-certification with the Fund to ensure coverage for those services. When a participant needs services requiring pre-certification, the participant or their provider should call the Fund or the Fund's Utilization Review vendor to pre-certify those services prior to treatment to avoid a reduction in benefits paid for that service.

PPO (preferred provider organization): Any appropriately licensed or certified health care professional or facility designated and accepted as a Participating Provider by Anthem BCBS to provide covered services to Fund members.

Psychologist: A person who specializes in clinical psychology and is licensed or certified as a psychologist or is a participant of the American Psychological Association.

Radiation Therapy: Treatment of a disease by x-ray, radium, cobalt or high-energy particle sources.

Respiratory Therapy: Treatment of illness or disease that is accomplished by introducing dry or moist gases into the lungs.

Skilled Nursing Facility (SNF): A licensed facility that provides nursing care and related services for patients who do not require hospitalization in an acute care setting.

Social Worker: A person who specializes in clinical social work who is trained to counsel patients and their families about their emotional or physical needs. The Social Worker must be licensed or certified as a social worker by the appropriate authority.

Specialists: Physicians whose practices are limited to treating a specific disease (e.g., oncologists), specific parts of the body (e.g., ear, nose and throat), a specific age group (e.g., pediatrician) or specific procedures (e.g., oral surgery).

Speech Therapy: Treatment to correct a speech impairment that resulted from birth or from disease, injury or prior medical treatment.

Trustees: The Fund Trustees, acting pursuant to the Agreement and Declaration of Trust establishing the Fund, and any successor Trustees, duly designated in the manner set forth in the Agreement and Declaration of Trust.

Urgent Care: When prompt medical attention is needed in a non-emergency situation. Examples of urgent care include ear infections, sprains, high fevers, vomiting and urinary tract infections. Urgent care situations are not considered to be emergency care situations.

Wage Class: There are three wage class earning and benefit levels — Wage Class I, Wage Class II and Wage Class III — used by the Fund to determine the level of benefits to which a participant and/or eligible dependents are entitled.