International Union of Operating Engineers Local 132

Health and Welfare Fund Summary Plan Description

2012 Edition

Contacting the Fund Office

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Huntington, West Virginia 25701-1321

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Office Hours

Monday through Friday
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Send Claims To

I.U.O.E. Local 132 H&W Fund
P.O. Box 2626
Huntington, West Virginia 25726-2626

This summary is available for you online at
www.iuoe132.org

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Introduction

About this Booklet

We are pleased to provide you with this updated International Union of Operating Engineers Local 132 Health and Welfare Fund Summary Plan Description. This booklet defines and describes the Health and Welfare Fund benefits. This booklet cancels and replaces all previous booklets and related material which you have been previously issued.

The Plan Year commences on July 1st and ends on June 30th, and consists of an entire twelve (12) month period for the purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies.

The Plan benefits are based on a calendar year.

Collective Bargaining Agreements, and the names of the parties thereto and their expiration dates, may be reviewed at the Fund Office. The Collective Bargaining Agreements are between the International Union of Operating Engineers Local 132 and various Employers that have entered into labor contracts with the Union.

A list of the Employers who participate in the Fund may be obtained either by writing to the Administrator or examined at the Fund Office by participants and their beneficiaries during normal business hours. Upon written request, the Administrator will furnish you with information as to whether a particular Employer participates in the Plan, and if so, their address.

Amendment and Interpretation of the Plan

The Trustees are empowered to amend the Plan and the benefits provided hereunder from time to time as they in their sole discretion determine appropriate. Participants will be advised of any material modification to the Plan by notice forwarded to their last known address by first class mail, postage prepaid.

The Trustees are empowered to construe and interpret the Plan and this Summary Plan Description, and any such construction and interpretation adopted by the Trustees in good faith shall be binding upon the Union, Employers, Employees and Participants.

Upon Becoming a Participant

When becoming a participant in the Plan, you will be provided an enrollment packet. It is important that you complete the Enrollment Form and return the requested information to the Fund Office so that we may update our records with the most complete and accurate information available. When you enroll a dependent, you will be required to provide proof of their dependent status.

You should contact the Fund Office any time you experience a life change, such as moving and changing your place of residence, getting married, the birth of a child, the adoption of a child, a legal separation from your spouse, or a divorce.

Should you have any questions or need assistance with your enrollment packet or any information regarding the Plan, feel free to contact the Fund Office.

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Your Health and Welfare Benefits

The following Schedule of Benefits briefly highlights the benefits available through the Plan and shows the payment percentages for both In-Network and Out-of-Network expenses. By utilizing providers which are In-Network, you will have lower out-of-pocket expenses as the Plan will process eligible expenses at a higher payment percentage. In-Network providers have also agreed to accept the allowable charges for eligible expenses, therefore you will not be responsible for the difference between the actual charge and the allowable charge.

As this schedule is only a summary, please refer to the appropriate sections of this booklet for more detailed information including any requirements for eligible expenses, as well as any limitations or exclusions from coverage. Benefits are subject to change. Please contact your Fund Office for the most up to date information regarding eligibility and covered expenses.

Schedule of Benefits

Annual Deductible	Individual Family	$250 $500
Annual Maximum for all Covered Expenses	Effective July 1, 2011 Effective July 1, 2012 Effective July 1, 2013 Effective July 1, 2014	$750,000 $1,250,000 $2,000,000 No limit
Maximum Out of Pocket Expense The Plan's payment factor will be increased to 100% for Covered Expenses in excess of $20,000 per calendar year (does not include the annual deductible)	Annual	$3,000 to $6,000
Oral/Vision Care Benefit	Maximum Reimbursement 100% Payment Factor	$500
Pediatric Oral/Vision Care	The first $500 is reimbursed at 100%, 50% reimbursement factor thereafter.	
Preventive Care Benefit	The first $1,000 is reimbursed at 100%, 50% reimbursement factor thereafter.	

Benefit and Payment Factors	In-Network	Out-of-Network
Hospital In-Patient Charges Room & Board charges Miscellaneous charges *Pre-Admission Certification Required*	85% of allowable charge	70%
Hospital Out-Patient Charges Pre-Admission Testing Anesthesiologist, Laboratory, Pathology, Radiology, Surgery and Testing charges	85% of allowable charge	70%
Emergency and Urgent Care Services Hospital Emergency Room Physicians Office Urgent Care facility	85% of allowable charge	70%
Ambulance Fees **Durable Medical Equipment (DME)** **Orthotic and Prosthetic Devices**	85% of allowable charge	70%
Physician Services Allergy Treatments Emergency and Urgent Care Mammograms Office Visits Pre-Admission Testing Second Opinions Specialists	85% of allowable charge	70%
Laboratory Services BC/BS network free-standing Laboratory facility Other Laboratory Services (billed through independent facility)	100% 85% of allowable charge	n/a 70%

Benefit and Payment Factors	In-Network	Out-of-Network
Radiology Services X-Rays, MRIs, MRAs, CAT scans and PET scans (billed through independent facility)	85% of allowable charge	70%
Chiropractic Treatment Limited to twenty (20) visits or a maximum of $1,000 per calendar year (including x-rays)	85% of allowable charge	70%
Physical Therapy and Speech Therapy Limited to a maximum of twenty (20) visits per calendar year per condition and must be medically necessary and not for developmental or educational expenses	85% of allowable charge	70%
Alcohol and Substance Abuse Treatment Limited to one (1) visit per day and fifty-two (52) visits per calendar year	85% of allowable charge	70%
Mental Health Care Treatment Inpatient Expenses	85% of allowable charge	70%
Mental Health Care Treatment Outpatient Expenses Limited to one (1) visit per day and fifty-two (52) visits per calendar year	85% of allowable charge	70%
Maternity Care Physician charges All prenatal and postnatal visits Delivery charges	85% of allowable charge see hospital inpatient	70% see hospital inpatient

Prescription Drug Benefits	
Annual Deductible	$100 per individual
At the Pharmacy 30 Day Supply per fill of a prescription	GENERIC You pay greater of $7.50 or 10% of the cost
	Preferred BRAND NAME You pay the greater of $20 or 20% of the cost
	Non-Preferred BRAND NAME You pay the greater of $35 or 30% of the cost
	The maximum co-payment for any one (1) prescription is $100.
Mail Order Program 90 Day Supply per fill of a prescription	GENERIC $20.00 per prescription
	Preferred BRAND NAME $40.00 per prescription
	Non-Preferred BRAND NAME $80.00 per prescription
Please refer to the Prescription Benefit Managers booklet for a listing of the Preferred Brand Name Drugs.	
Should you receive a Brand Name drug when a Generic equivalent is available, you will be required to pay the difference between the cost of the Brand Name and the cost of the Generic.	

Life Insurance Benefits

Participant	
Life Insurance	$25,000
Accidental Death & Dismemberment (AD&D)	$25,000
Dismemberment and Loss of Sight	
Loss of two arms or legs or sight in both eyes	$25,000
Loss of one arm or leg and sight of one eye	$25,000
Loss of one arm, one leg, or sight of one eye	$12,500
Dependents	
Spouse	$10,000
Children 24 hours after live delivery but less than 19 years of age (to age 23 if continuing to meet the dependent definition)	$5,000

The Life Insurance, AD & D and Dependent Life Insurance Benefits are underwritten by an insurance company.

Weekly Disability Benefit

Weekly Disability Benefit	$200
Waiting Period for Injury	0 days
Waiting Period for Illness	7 days
Maximum Benefit Period	26 weeks

No benefits are payable for a work related injury or illness. This benefit is subject to FICA and Medicare taxes. A Form W-2 will be provided annually for all benefits paid.

The weekly disability benefit is for active participants only and does not apply to a retiree, spouse or an eligible dependent.

Eligibility

Initial Eligibility by Hours

Each person employed by an employer participating in the International Union of Operating Engineers Local 132 Health & Welfare Fund and is covered by a collective bargaining agreement between his employer and the International Union of Operating Engineers Local 132, AFL-CIO (Union) shall become eligible for benefits in accordance with the "Qualifying Schedule", provided appropriate monthly contributions have been made to the Fund on his account by a Participating Employer or Employers.

Initial Eligibility by Self Contributions

A new employee or a participant who has not been eligible for twenty-four (24) or more months who works 120 hours with a Participating Employer during not more than the preceding twelve (12) months may make a self-contribution to initially become eligible for benefits in accordance with the following schedule:

If you work 120 or more credited hours with Participating Employers during the 12 month period ending:	You will be permitted to make the appropriate self-contributions for coverage for the months of:
January 31	March and April
February 28 (29)	April
March 31	May, June and July
April 30	June and July
May 31	July
June 30	August, September and October
July 31	September and October
August 31	October
September 30	November, December and January
October 31	December and January
November 30	January
December 31	February, March and April

Qualifying Schedule

Eligibility for benefits is based upon the satisfaction of minimum contribution credits during a Work Quarter (or Work Quarters, in some cases). Coverage is provided for the associated Benefit Quarter. Benefit Quarters are three-month periods beginning on:

February 1st	For coverage February 1st through April 30th
May 1st	For coverage from May 1st through July 31st
August 1st	For coverage from August 1st through October 31st
November 1st	For coverage from November 1st through January 31st

Below is a table describing the contribution hour requirements for each Benefit Quarter:

Benefit Quarter Beginning	Work Quarters
February 1st	325 hrs during the previous October thru December; or, if not, Then 650 hrs during the previous July thru December; or, if not, Then 975 hrs during the previous April thru December; or, if not, Then 1,300 hrs during the previous January thru December.
May 1st	325 hrs during the previous January thru March; or; if not, Then 650 hrs during the previous October thru March; or, if not Then 975 hrs during the previous July thru March; or, if not, Then 1,300 hrs during the previous April thru March.
August 1st	325 hrs during the previous April thru June; or, if not, Then 650 hrs during the previous January thru June; or, if not, Then 975 hrs during the previous October thru June; or, if not, Then 1,300 hrs during the previous July thru June.
November 1st	325 hrs during the previous July thru September; or, if not, Then 650 hrs during the previous April thru September; or, if not, Then 975 hrs during the previous January thru September; or, if not, Then 1,300 hrs during the previous October thru September.

Coverage Effective Date

You will become covered for benefits on the date you meet the Initial Eligibility requirements or the Qualifying Schedule requirements.

Continuation of Eligibility

Once having become eligible, you shall remain eligible for a full quarter (three consecutive months). Thereafter, to remain eligible, an employee must be credited with contributions for the work hours specified in the "Qualifying Schedule".

Should you have been eligible for the previous quarter and not reach the required hours for coverage in the following quarter, you will be permitted to self-pay for the shortage of hours required to maintain your eligibility in the Plan determined by deducting the hours worked and reported from the required three hundred and twenty-five (325) hours. The deficit hours are paid at the current contractual contribution rate.

Coverage Termination Date

Your coverage under the Plan will terminate on the earliest of the following:

- The date the Plan terminates;
- The date you are no longer a member of an eligible class;
- The date on which a self-contribution is due and unpaid;
- The date on which a self-contribution payment is rejected by a bank for insufficient funds; or
- The date a change is made in the Plan to terminate benefits for your class.

Your Dependents' Benefits will terminate on the earliest of the following:

- The date your coverage terminates;
- The date a change in the Plan terminates dependents' benefits;
- The date a dependent is no longer an Eligible Dependent, as defined.

Your continued eligibility for benefits will cease immediately if you become employed without the Union's consent by an employer who is not required to make contributions to the Fund or if you become employed outside the Fund's jurisdiction by any employer for whom you perform work commensurate with that considered to be in the same industry, trade or craft as you performed while working in this Fund's jurisdiction.

Coverage for Your Dependents

Your dependents will become eligible for coverage when you become eligible, or when they become a dependent, if later.

When you become eligible for coverage, you will be provided an enrollment package and you will need to complete the required Enrollment forms. For a dependent spouse, you will need to provide a marriage certificate and birth certificate and for each dependent child, you will need to provide a birth certificate and adoption papers, if applicable.

Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is an order issued by a state court that requires an employee to provide coverage for a child under a group health plan. A QMCSO is generally the result of a legal separation or a divorce. In the event of a Qualified Medical Child Support Order, you are required to provide for dependent coverage.

A National Medical Support Notice is an order also issued by a state court or Child Support Agency. Receipt of this type of notice constitutes a Medical Child Support Order and requires the Fund to add a dependent child to your coverage.

Coordination of Benefits

When there is coverage under more than one group plan, the plan that determines benefits first is called the primary plan, and allows for benefits as provided under the plan. The plan that determines benefits after the first plan is called the secondary plan and benefits are limited so that the total amount from all the group plans will not be more than the actual amount of covered expenses incurred.

The rules for which the Health and Welfare Fund will follow for determining which plan is the primary plan are as follows:

- A plan without a coordination clause will always pay first.
- The plan covering the patient as an employee is primary and the plan covering the patient as a dependent is secondary.
- For a dependent child that is covered under both parent's plans, the plan of the parent whose birthday is earlier in the year is primary and the other parent's plan is secondary. (Should both parents have the same birthday, then the plan that has covered the parent longer will be primary.)

- The plan that covers an individual as an active employee is primary and the plan that covers the individual as an inactive employee is secondary. (A participant who is retired or self-paying for COBRA coverage is considered an inactive employee.)
- The plan that covers an individual as an active employee is primary to the plan covering the individual as a self-pay participant.
- The plan covering the individual as other than a COBRA participant pays first. (If both plans do not have this rule, it is ignored.)

In the case of divorced parents, the following line of benefit determination is applied:

- The plan of the parent with custody of the dependent child pays benefits first.
- The plan of the spouse of the parent with custody of the child pays second.
- The plan of the parent without custody of the dependent child pays last.

If none of the above situations apply, the plan which has had the individual covered the longest period of time is primary.

If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be primary and any other plan which covers the child as a dependent will be secondary.

In applying the rules for determining which plan is the primary carrier, the provisions of any plan which would attempt to shift the status of this Plan from secondary to primary by excluding from coverage under such other Plan, any participant or dependent eligible under this Plan, shall not be considered.

In the event another plan is determined to be primary and such other plan is either not financially able or refuses to discharge its responsibility such action shall not cause this plan to assume the primary status.

In the event an employee or dependent fails or refuses to comply with the terms and conditions of another plan, thereby resulting in that other plan reducing or denying benefits, this Plan will only provide benefits under the coordination of benefits provision based upon the benefits which the other plan would have provided if the employee or dependent

had fully and properly complied with the terms and conditions of the other plan.

Reinstatement of Coverage

A participant having lost eligibility for a period of not more than eighteen (18) months may once again become eligible for benefits after having contributions paid on his or her behalf by a contributing employer for at least two hundred (200) hours in any work quarter, and self-paying the deficit hours determined by deducting the hours worked from the three hundred twenty-five (325) hours required. The deficit hours shall be paid at the current contractual contribution rate.

If your Dependents' benefits would otherwise terminate due to your death, your Dependents' benefits will continue until the end of the Eligibility Quarter for which you would have been eligible.

A Surviving Spouse may continue benefits on a monthly basis by paying the self-contribution established by the Fund until such time as they become entitled to benefits under Medicare at which time they will be permitted to purchase a Medicare supplement benefit package through self-contributions on a monthly basis. **Failure to make any necessary self-contribution when due will result in a forfeiture of the right to make future self-contributions.**

In order to continue eligibility in this manner the Surviving Spouse must reject the COBRA continuance option.

Self-Contribution Provisions

For Active Participants

Participants whose benefits would otherwise terminate due to insufficient hours may elect to continue to be eligible under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as further explained later in this booklet.

Such participants may also elect to continue to be eligible on a self-pay basis provided they self-pay the necessary contributions to the Fund and during such period do not accept employment in the construction industry with an employer who is not obligated to make contributions on their behalf to the Fund or to another Health and Welfare Fund maintained by any other International Union of Operating Engineers Local Union, subject to the following:

- If you work at least one (1) hour during any Work Period, you may self-pay for the corresponding Eligibility Quarter.

- If you work zero (0) hours, you may self-pay for a maximum of four (4) consecutive Eligibility Quarters.

Once you have made the maximum of four (4) consecutive full self-contributions on a quarterly basis you will be permitted to maintain your eligibility for benefits on a monthly basis. You will be permitted to continue eligibility on a monthly basis through self-pay for a maximum period of twelve (12) consecutive months.

Any period of eligibility maintained through self-payment will be considered as part of the coverage period mandated by COBRA.

If the participant fails to make any necessary self-pay contribution when due, they will lose their right to make future payments.

For Non-Medicare Retirees

If you retire under a qualified pension plan prior to age sixty-five (65) and if you were eligible for benefits under this plan at the time of your retirement and for a total of sixty (60) Eligibility Quarters over your working lifetime, you will be permitted to continue your eligibility for benefits, except Weekly Disability and AD & D Benefits, through self-contributions. You must complete an application for continued benefits and make continuous payments. If your benefits terminate for failure to make a payment when due, you will not be permitted to reinstate benefits unless the initial eligibility requirements are again met.

Upon attaining Medicare age or qualifying for Medicare due to disability, you will be permitted to purchase the Medicare Supplement benefits described in the "**For Retirees Eligible for Medicare**" section.

If you work in a jurisdiction outside the Fund's area and elect to authorize the transfer of reciprocal hours to this Fund, your hours earned will be credited based upon the Work Quarter and eligibility will be granted for the ensuing Benefit Quarter. If necessary for you to maintain coverage, you will be permitted to make a self-contribution in an amount equal to the difference between the required hours for eligibility and the number of hours credited times the prevailing building trades contribution rate applicable under the terms of the IUOE Local 132 Collective Bargaining Agreement in effect at the time.

Upon the cessation of active employment and the payment of the final partial self-contribution as an active employee, you will be permitted to

reinstate coverage as a retiree by paying the required self-contribution amount, provided there is no break in the continuity of coverage periods.

Participants in the Fund who retire after their sixty-second (62nd) birthday, continue eligibility in the Fund and who were unmarried at the time of retirement but subsequently marry may apply within sixty (60) days of marriage for coverage of their spouse. Such coverage will exclude expenses for any condition for which the spouse has been diagnosed or received medical treatment (including prescription medicines) within one (1) year prior to the marriage and will be contingent upon payment of the required contribution.

For Retirees Eligible for Medicare

If you retire under a qualified pension plan at age sixty-five (65) or after (when eligible for benefits through Medicare) and if you were eligible for benefits under this plan at the time of your retirement and for a total of sixty (60) Eligibility Quarters over your working lifetime, you will be permitted to purchase coverage by self-contribution to supplement benefits under Medicare. Life Insurance, AD & D, Weekly Disability and Dependent Life Insurance benefits are not provided with the Medicare supplemental benefits program. You must complete an application for continued benefits and make continuous payments. If your benefits terminate for failure to make a payment when due, you will not be permitted to reinstate benefits unless the initial eligibility requirements are again met.

If you work in a jurisdiction outside the Fund's area and elect to authorize the transfer of reciprocal hours to this Fund, your hours earned will be credited based upon the Work Quarter and eligibility will be granted for the ensuing Benefit Quarter. If necessary for you to maintain coverage, you will be permitted to make a self-contribution in an amount equal to the difference between the required hours for eligibility and the number of hours credited times the prevailing building trades contribution rate applicable under the terms of the IUOE Local 132 Collective Bargaining Agreement in effect at the time.

Upon the cessation of active employment and the payment of the final partial self-contribution as an active employee, you will be permitted to reinstate coverage as a retiree by paying the required self-contribution amount, provided there is no break in the continuity of coverage periods.

Consolidated Omnibus Budget Reconciliation Act
COBRA

Medical Benefits Continuance Provisions

Medical Benefits as used in this provision means major medical and prescription drug benefits provided under the Plan on an expense-incurred basis.

Continuation of Group Medical Benefits

1. You may elect to continue medical benefits for yourself and your eligible dependents for as long as eighteen (18) months from the day your eligibility ends because of:

   (a) Your employment terminates (other than due to gross misconduct); or
   (b) You no longer satisfy the requirements for hours worked.

2. You or your dependents may elect to continue medical benefits for yourself and/or your dependents for an additional eleven (11) months following the original eighteen (18) month period if eligibility ends due to total disability on the date of or within sixty (60) days of the Qualifying Event and Social Security Disability Benefits awarded. Proof of total disability must be provided to the Fund Office prior to the expiration of the eighteen (18) month continuation period described above.

3. Your eligible spouse and/or any eligible dependent children may elect to continue medical benefits for as long as thirty-six (36) months from the day eligibility ends because:

   (a) You die;
   (b) You become entitled to Medicare benefits;
   (c) You and your spouse are legally separated;
   (d) You marriage is ended by divorce; or
   (e) A child is no longer an eligible dependent.

   You are responsible for notifying the Fund Office when medical benefits end in accordance with 3(c), 3(d) or 3(e) above.

   The Fund Office will send you or your dependent written notice of the right to continue medical benefits. The Fund Office must receive your or your dependent's written request to continue medical benefits by the later of:

(a) Sixty (60) days after the day medical benefits end; or
(b) Sixty (60) days after the notice is received.

Continued coverage may only begin on the day after medical benefits under the Plan ends. You or your dependents must pay the required premium, including any retroactive premium, from the day the coverage would have otherwise ended. The premiums must be paid to the Fund Office within forty-five (45) days after the day continued coverage is elected. The Fund Office will inform you or your dependent of the monthly premium to be paid.

4. Continued medical benefits will end at midnight on the earliest of:

(a) The day the Fund ceases to provide any group health plan;
(b) The day the premium is due and unpaid;
(c) The day the covered person, after the date of the COBRA election, first becomes covered under another group plan that does not contain a pre-existing conditions limitation or such limitation is not applicable to the covered person due to the absence of a pre-existing condition. (A plan's pre-existing conditions limitation period will be reduced by each month that you or your family had continuous health coverage (including COBRA) with no break in coverage greater than sixty-three (63) days. When your coverage ends, you will receive certification of the duration of your COBRA coverage. This provision applies individually to each COBRA beneficiary.);
(d) The day a covered person again becomes covered under the Plan;
(e) The day a covered person, after the date of the COBRA election, is entitled to benefits under Medicare;
(f) The day medical benefits have been continued for the period of time provided in 1, 2 or 3 above;
(g) The date the Social Security Disability Award is revoked (which entitled the person to continue coverage beyond the eighteen (18) month continuance period); or
(h) The first of the month for which the premium payment is rejected by that person's bank for insufficient funds.

IMPORTANT: In the event more than one (1) continuation provision applies, the periods of continued coverage will run concurrently up to a maximum of thirty-six (36) months.

Any period of continued eligibility for surviving spouses of deceased participants provided by the Plan will not reduce the period of continuation mandated under this provision.

Comprehensive Major Medical Benefits

These benefits will be payable if you or your dependents, while covered, incur covered charges which exceed the Deductible amount. These Benefits provide you with coverage for any illness or injury that is not employment related.

Your Benefits

Benefits are payable, as shown in the Schedule of Benefits, for covered charges that you, or one of your dependents, incur within a calendar year, which are in excess of the Deductible.

The Deductible

The Deductible is an "out-of-pocket" expense which you and your Dependents are required to pay before you are entitled to Comprehensive Major Medical Benefits. The Deductible amount is shown in the Schedule of Benefits.

The Deductible applies only once in the calendar year. Any expenses incurred in the last three (3) months of a calendar year which are used to satisfy the Deductible, in part or in full, will also be applied to reduce the Deductible for the following calendar year.

Common Accident

If two (2) or more covered members in a family are injured in the same accident, only one Deductible has to be met during that calendar year and the following calendar year for covered charges which are incurred as a result of the common accident. Separate Deductibles will still apply to charges not related to the common accident.

Maximum Benefits

The annual maximum amount payable with respect to all illnesses or injuries is shown below:

Effective July 1, 2011	$750,000 per individual;
Effective July 1, 2012	$1,250,000 per individual;
Effective July 1, 2013	$2,000,000 per individual;
Effective July 1, 2014	No annual limit per individual.

Eligible Medical Expenses

Benefits are payable for the Reasonable and Customary charges incurred for treatment, services and supplies ordered by a Physician for care and treatment of an injury or illness covered under the Plan. The level of reimbursement depends on if you utilize In-Network or Out-of-Network providers (refer to the Schedule of Benefits). Eligible medical expenses are as follows:

Ambulance Service

- Charges for a licensed professional ambulance service for transportation to or from a hospital

Pre-Admission Testing

- Charges for tests required before a hospital admission performed in a physician's office or outpatient facility.

Hospital

- Inpatient Hospital charges for the first one hundred and eighty (180) days for inpatient treatment per confinement. Covered room and board charges may not exceed the hospital's average rate for semi-private rooms.
- Critical Care Units (CCU) and Intensive Care Units (ICU).
- Pre-Admission tests required before a hospital admission
- Routine nursery care or maternity care of a newborn child during the mother's inpatient hospital stay
- Staff physician visits and treatment of a medical condition and inpatient nursing services by a registered graduate nurse (RN)
- Services provided by anesthesiologists, pathologists, radiologists, surgeons and other physicians who visit or treat you while in the hospital
- Charges for blood and blood plasma, and the administration thereof
- Prescribed drugs, medications, intravenous injections and solutions
- Any miscellaneous charges which are customarily provided to treat a medical condition that resulted in the hospitalization
- Charges by a Hospital for outpatient treatment
- Charges by a Hospital or licensed rehabilitation facility for treatment of alcoholism or drug addiction upon the recommendation and approval of a licensed Physician

Emergency and Urgent Care

The Plan provides coverage for emergency and urgent care services provided in a physician office, hospital emergency room or urgent care facility.

Preventive Care

Benefits for preventive care, as detailed below, will be paid at 100% of the first $1,000, then 50% thereafter per covered individual, without application of the calendar year deductible. Covered services include:

- Mammogram, limited to one exam per calendar year
- Pap smear and related office visit, limited to one such exam per calendar year
- HPV testing and vaccination, limited to one exam per calendar year
- Immunizations, including vaccines and flu shots
- Routine physical exam, limited to one exam per calendar year
- Prostate exam, limited to one exam per calendar year
- Colonoscopy exam for screening purposes, limited to:
  - One exam every ten (10) years, if under age fifty (50)
  - One exam every five (5) years, if age fifty (50) and over

Benefits will not be provided under this Preventive Care Benefit for treatment, including diagnostic testing, of any illness or injury. Charges for treatment of an illness or injury will be considered under the Comprehensive Major Medical Benefit as detailed in this booklet.

Laboratory Benefit

The Plan provides for FREE outpatient laboratory testing when your specimens are processed by a free-standing Blue Cross Blue Shield network laboratory facility, and you pay no deductible, no co-payments, and no co-insurance for testing that is covered by your medical plan. Please note, this benefit will not apply to laboratory charges submitted by a hospital, whether the patient is confined or not confined.

You can call the Provider Locator phone number listed on the back of your H&W Identification card to access a listing of providers which are the Blue Cross Blue Shield network.

Should you need testing on an emergency basis, or choose not to use your Lab Card, your regular benefits will apply.

Should Medicare be your primary insurance, or should you be a dependent with another primary insurance carrier, your claim will need to be processed by Medicare, or your primary insurance carrier, before this Plan can process your claim and coordinate benefits.

Office Visits

The Plan provides coverage for office visits to a physician and specialist and for surgery performed in the physician's office. Typical types of charges included:

- Physician and specialist charges for diagnosis, treatment and surgery
- Charges related to providing a second opinion
- Drugs and medicine which, by law, require a Physician's written prescription
- Services by a physiotherapist under the supervision of a Physician

Surgery

- Surgical procedures performed on both an inpatient and outpatient basis
- Cosmetic surgery required by an accidental bodily injury which occurred while covered by the Plan
- Reconstructive surgery due to a congenital disease or anomaly of a dependent child which has resulted in a functional defect
- Gastric By-Pass or Gastric Banding up to a maximum of $25,000
- Mastectomy, including:
    - Reconstruction of the breast on which the mastectomy has been performed
    - Surgery and reconstruction of either or both breasts to produce a symmetrical appearance
    - Prostheses and treatment of physical complications in all stages of mastectomy, including lymphedemas

Should your physician recommend an elective surgery, the Plan also provides coverage for a second opinion.

Facility Fees

The Plan provides coverage for surgical or outpatient procedures and treatments performed at a free-standing facility.

Mental Nervous

Charges for Day Treatment Program expenses for the outpatient treatment of substance abuse and psychiatric counseling, including pain management, provided the day treatment care meets all of the following requirements:

- Follows an inpatient confinement of at least three (3) days;
- Commences within three (3) days of the hospital discharge;
- Is recommended by a physician; and
- Is rendered by a provider licensed for such treatment by the state of domicile.

Oral / Vision Care Benefit

If while covered, you or an eligible dependent incur expenses for oral or vision care services which are not covered under the Major Medical Benefit, such expenses will be reimbursed at 100%. The maximum benefit which will be paid on behalf of any covered individual is $500 for expenses incurred in a calendar year.

In regards to pediatric oral/vision care, if an eligible minor child(ren), age 19 or less, incurs expenses for oral or vision care services which are not covered under the Major Medical Benefit, such expenses will be reimbursed at 100% of the first $500, then 50% thereafter.

Please note, Orthodontics are not considered as an “essential health benefit”, and are not covered under the Oral Care Benefit.

This benefit is intended to be a reimbursement arrangement where you pay the service provider’s bill and submit a receipt to the Fund Office for reimbursement. If you and the service provider can reach an agreement where the provider will accept payment from the Fund, with you responsible for the difference, you can instruct the service provider to submit his bill directly to the Fund Office and the Fund’s check will be made payable to the service provider.

Dental Work or Treatment

The Plan provides coverage for dental work, surgery or treatment required to repair, replace, restore or reposition sound natural teeth or other body tissues as a result of an injury that occurred while the patient was covered under the Plan. Coverage is also provided for:

- Charges for the treatment of a cleft lip or palate;
- Charges for the treatment of temporomandibular joint disease (TMJ), including office visits and bite splints, excluding orthodontic treatment and retainers;
- Charges for the treatment of cysts or tumors; and
- Charges for the treatment of cancer of the jaw or mouth.

Eye Care or Treatment

The Plan provides coverage for the treatment of glaucoma and cataracts, and also for charges related to an accidental eye injury occurring while eligible for benefits. The Comprehensive Major Medical Plan does not provide coverage for routine eye refractions, eyeglasses, contact lenses or charges for eye surgery or treatment primarily to correct refractions.

Chiropractic Care

The Plan provides coverage for chiropractic care provided by a chiropractor, limited to either a maximum of twenty (20) visits per calendar year or a total of $1,000, whichever occurs first. Charges for x-rays are included in this benefit.

Physical Therapy and Speech Therapy

The Plan provides coverage for physical therapy, limited to a maximum of twenty (20) visits per condition per calendar year. The therapy must be medically necessary and not for developmental or educational purposes.

Charges related to speech therapy must be medically necessary, require a treatment plan and may initially be approved for twenty (20) visits. Additional visits may be permitted after the review of therapist's documentation and progression. Speech therapy is limited to a maximum of forty (40) visits.

Maternity Care

The Plan provides coverage for physician charges for all obstetrical care, including the initial visit and all prenatal and postnatal visits, and delivery in a hospital or birthing center. Newborn benefits include the hospital's nursery charges incurred during the mother's confinement.

Also covered are services rendered by a birthing center (as defined by State Law) including any charges for care rendered by a licensed nurse-midwife (or by a midwife as defined by State Law) providing services within the scope of his license as permitted by State Law.

You must enroll a newborn within thirty (30) days after birth in order for the Plan to identify the dependent on future claims.

Premature Birth and Congenital Malformation

Medical expenses incurred while you are covered with respect to a dependent child for treatment of a child's premature birth or congenital malformation will be considered for benefits as though such expenses were due to a disease of the child. Premature birth will be deemed to have occurred only if a doctor certifies to such prematurity and the child requires confinement in an incubator or the premature baby room of a hospital.

Abortions

The Plan covers both elective and therapeutic procedures for participants and covered dependents.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (i.e.: your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits for out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours (or ninety-six (96) hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

Weekly Disability Benefits

The Plan provides coverage should you become totally disabled due to a non-occupational accidental bodily injury or disease. Benefits will begin on the day of disability following the applicable waiting period specified in the Schedule of Benefits and will continue during the continuance of total disability for up to twenty-six (26) weeks. The amount of the benefit is shown in the Schedule of Benefits.

If while covered, you become totally disabled due to pregnancy, you will be eligible for this benefit, subject to the same provisions regarding commencement and duration of benefits as would be applicable to any disease.

Successive periods of disability separated by less than two (2) weeks of continuous full-time active work shall be considered as one period in determining the benefits available to you, unless the subsequent disability is due to an injury or disease entirely unrelated to the cause of the previous disability and commences after your return to full-time active work.

This benefit will not be payable for a disability due to injury or disease for which you are not under regular treatment by a physician.

Skilled Nursing

A Skilled Nursing Facility provides for a level of service that are often essential after a hospital stay, such as rehabilitation, physical, speech, or occupational therapy. The Plan provides coverage for room and board charges and requires the attending physician to certify the admission to the facility is medically necessary as a substitute for hospital confinement. Skilled nursing is limited to coverage for up to sixty (60) days and must be for patient rehabilitation. A Skilled Nursing Facility must meet the following requirements:

- Licensed physician on call 24 hours a day;
- Registered Nurse (RN) on duty 24 hours a day;
- Each patient must be under the care of a physician; and
- Skilled Nursing Facility must be licensed by the State.

The Plan does not provide coverage for charges related to a convalescent nursing home, rest facility or facility for the aged that furnishes primarily Custodial Care, including training in routines of daily living.

Home Health Care

Home Health Care is generally for the treatment of an illness or injury in the patient's home and begins immediately following an inpatient hospital stay. The Plan provides coverage only for medically necessary services and supplies which are rendered to a patient at home by a licensed agency or individual, excluding a family member or resident of the household. No coverage is provided for custodial care, housekeeping services, child care, cooking, bathing or laundry services. Home Health Care coverage must meet the following requirements:

- Condition calls for intermittent (part-time) Registered Nurse (RN) care, physical, speech, or occupational therapy;
- Individual is confined to the home; and
- A physician determines home health care is needed and sets up the home health care plan.

Hospice Care

Hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management, and support services to terminally ill patients and their families. The Plan provides coverage for the following:

- Outpatient medical and support services from an approved Hospice;
- Outpatient nursing care provided by a Registered Nurse (RN);
- Physical or occupational therapy or speech language pathology.

The Plan does not provide coverage for Hospice charges for an In-patient Hospital environment.

Diabetic Services and Supplies

The Plan provides coverage for services and supplies related to the care and treatment of diabetes. Coverage is also provided for glucometers, blood glucose monitors and infusion devices, including charges for insulin needles and syringes, visual reading strips, urine test strips and injection aids such as lancets and alcohol swabs.

Outpatient educational or training charges by a certified nutritionist or licensed dietitian are limited to a lifetime maximum of $500.

Durable Medical Equipment

The Plan provides for monthly rental to the purchase price of durable medical equipment (DME) when prescribed by a physician. Charges for repair are covered due to reasonable wear and tear usage. Replacement costs are covered only if the durable medical equipment is unable to be repaired or due to the patient's growth or anatomical changes.

Durable medical equipment must be medically necessary and some equipment requires specific criteria to be met before being approved for coverage. Typical types of durable medical equipment are as follows:

- Wheelchairs
- Hospital type beds
- Iron lungs
- Dialysis machines
- Kangaroo Pumps
- Nebulizers
- Oxygen concentrators
- C-Pap or Bi-Pap *(for moderate to severe sleep apnea)*

The Plan provides coverage for the supplies required for the administration of covered durable medical equipment.

No benefits are payable for items which are not medically necessary and are considered as convenience items. Typical types of equipment which are ineligible expenses include, but are not limited to:

- Air purifiers, humidifiers and vaporizers;
- Bed related items such as mattresses, pillows and tables;
- Bath related items such as grab bars, rails, raised toilet seats and bath benches;
- Heat lamps, sun lamps, heating pads or any form of ultraviolet beds or cabinets; and
- Pools or spas for aqua therapy.

Orthotics

The Plan provides coverage for orthotic devices which are medically necessary to support or aid in the treatment of an injury or illness and prescribed by a physician. Coverage is also provided for all medically necessary supplies, adjustments, repairs or replacement of covered orthotic devices. Replacement of orthotics is generally provided following a malfunction of the device, for growth adjustments, or after the device's normal life span. Typical types of orthotics are:

- Splints and Trusses
- Braces for the arm, back, leg, neck, or shoulder
- Custom molded foot orthotics

The Plan provides coverage for foot orthotics if they are custom molded from a mold of the patient's foot and prescribed by a physician. Orthopedic shoes are not eligible for coverage unless one or both of the shoes are an integral part of a leg brace.

Over the counter support devices are not eligible for coverage.

Prosthetics

The Plan provides coverage for prosthetic devices such as artificial limbs or eyes, which are prescribed by a physician as a replacement of a natural limb or eye lost while a covered individual and must be medically necessary for the correction of an injury, illness or congenital defect.

The Plan provides coverage for the initial purchase and fitting of the device. Coverage is also provided for repairs and replacements which are due to reasonable wear and tear or anatomical changes that are not otherwise provided under the manufacturer's warranty or purchase agreement. No coverage is provided for repairs or replacements that are the result of a covered individual's misuse.

A prosthetic device requires a Letter of Medical Necessity from the physician. Typical types of prosthetics are as follows:

- Basic limb prosthetic
- Eye prosthetic
- Breast prosthetic — *Coverage for two per side, every five years*
- Penile prosthetic
- Bra — *Coverage for two every five years*
- Wig — *Coverage for hair loss due to cancer treatment*

Women's Health & Cancer Rights Act

Your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas.

Coverage of breast reconstruction may be subject to the deductible and coinsurance factors.

Ineligible Medical Expenses

No benefits are payable for the following expenses:

- Services, supplies and treatment that are not medically necessary, as defined by the Plan;
- Charges which are in excess of the Reasonable and Customary charges (as defined) for services, supplies and treatment;
- Charges which are in excess of the contracted allowable charge for In-Network benefits;
- Expenses for work related injuries, illnesses or medical expenses covered under Workers' Compensation or any state or Federal Law (unless benefits are denied and the appeal process has been exhausted);
- Hospital charges for personal or comfort items such as personal care kits and other items which are not for the specific treatment of an injury or illness;
- Services rendered during confinement in a hospital owned or operated by the Federal Government, unless you would be required to pay such charges in the absence of coverage;
- Loss due to war, either declared or undeclared, or loss suffered while engaged in military service;
- Expenses which were incurred before you became eligible for benefits and expenses which were incurred after your coverage terminated;
- Expenses you or your dependents are not required to pay;
- Expenses in excess of the Plan's annual and lifetime limits;
- Expenses for eyeglasses or contact lenses and charges for eye surgery or treatment primarily to correct refractions;
- Dental work or treatment, except for the accidental injury to sound natural teeth occurring while covered or for the treatment of cysts and tumors or cancer of the jaw or mouth;
- Charges for hearing aids or any device which assists in hearing;
- Charges related to cosmetic surgery unless caused by an accidental bodily injury occurring while covered or reconstructive surgery due to congenital disease or anomaly of a dependent child which has resulted in a functional defect;

- Charges related to breast augmentation solely for cosmetic purposes;
- Routine physical examinations, except as provided for elsewhere;
- Transportation, except for licensed professional ambulance services;
- Expenses related to an injury sustained when it is determined the covered individual was intoxicated under the laws of the state where the accident occurred or the result of being under the influence of a drug, unless the drug was prescribed by a physician and used strictly as prescribed;
- Intentionally self-inflicted injury or injury sustained in the commission of a felony, unless the injury is the direct result of a medical condition (such as mental illness or depression);
- Expenses for outpatient treatment of Mental and Nervous disorders unless provided by a licensed clinical psychologist or psychiatrist, licensed professional counselor, or licensed social worker;
- Charges for preparing medical reports, itemized bills or claim forms, handling, mailing, shipping expenses or sales tax;
- Charges for missed appointments or “no show” fees;
- Membership fees or costs associated with health clubs, weight loss programs and smoking cessation programs;
- Infertility treatment and services including In Vitro Fertilization (IVF), Gamete Intra Fallopian Transfer (GIFT) or any other variations of these types of procedures;
- Charges associated with the collection, washing, preparation or storage of sperm for artificial insemination and charges for cryopreservation of donor sperm and eggs;
- Charges for a reversal of a voluntary sterilization;
- Charges for routine foot care, including service for calluses, corns or toenails, unless medically necessary;
- Convalescent care or nursing homes; and
- Experimental treatments or services.

The Plan benefits outlined in this booklet are subject to change. Contact the Fund Office to confirm whether a service or procedure is an Eligible Medical Expense or an Ineligible Medical Expense.

Pre-Existing Conditions Limitations

A Pre-Existing Condition is an injury or illness for which you or your dependent receives medical care, medical treatment, including prescribing of prescription drugs, or for which a diagnosis was made in the six (6) month period prior to the effective date of your coverage or the effective date of your dependent's coverage.

The Plan will make no payment towards an expense incurred related to a Pre-Existing Condition until the earlier of:

- The end of a continuous six (6) month period during which you or your covered dependent do not receive care or treatment for the Pre-Existing Condition; or
- The end of a continuous twelve (12) month period measured from the effective date of coverage.

This Pre-Existing Conditions limitation will apply to all plan participants and their dependents upon their initial eligibility for plan benefits and will reapply to all Plan participants and dependents upon reinstatement of their plan eligibility following a break in coverage of six (6) or more consecutive months.

This limitation will be waived in whole or in part upon the presentation of a Certificate of Creditable Coverage, providing a break in coverage of less than sixty-three (63) days existed between the cessation of coverage under a prior plan and the commencement of eligibility under this plan. You can contact the Fund Office for more information or if you have other questions.

The Pre-Existing Conditions limitation does not apply to the Life Insurance, Accidental Death and Dismemberment or Weekly Disability benefits. This provision will not apply to covered maternity expenses incurred by a participant or spouse or to covered expenses of a newborn or a newly adopted child under the age of eighteen (18), if enrolled within thirty (30) days of adoption. Further, there are no Pre-Existing Conditions Limitation for children less than age nineteen (19).

Subrogation

If the Fund makes a payment under the terms of this Plan and the individual to or for whom the payment was made has a right to recover damages from another, the Fund shall be subrogated to that right to the

extent of the payment of benefits made by this Plan. The recipient of benefits shall do nothing to prejudice this right. Should a recipient of benefits recover damages from another, the recipient shall hold the proceeds in trust for the Fund to the extent of the Fund's payment.

Once a Third Party's liability is resolved the individual will be required to reimburse the Fund up to the full amount of the recovery for the full amount of benefits received. In such cases, the acceptance of benefits constitutes an agreement to reimburse the Fund for benefits paid up to the full amount of recovery. By accepting benefits from the Fund, the injured party agrees that any amounts recovered by the injured party by judgment, settlement or otherwise will be applied first to reimburse the Fund.

Fund's Right of Recovery

The Fund has the right to recovery from any Participant, or any other individual or recipient of Plan benefits, any payments made as a result of misrepresentation, mistake or error, irrespective of the party causing such mistake or error.

Prescription Drugs and Medicines Benefit

The Plan provides benefits for Covered Prescription Expenses in excess of the Deductible and Co-payment amounts. These benefits are provided through an independent Prescription Benefit Manager.

Covered Prescription Expenses

Covered Prescription Expenses are necessary and reasonable expenses incurred for drugs and medicines which require a doctor's prescription, and injectible insulin prescribed by a physician, which are necessary in the treatment of an illness.

Deductible and Co-Payment Amounts

The Deductible amount is an expense which you or your dependents are required to pay before you are entitled to prescription benefits. The Co-Payment is the amount you must pay for each prescription before a

benefit is payable by the Plan. The calendar year deductible and the co-payment factors are shown in the Schedule of Benefits.

Limitations

The Plan does not provide coverage for any of the following types of expenses:

- Drugs or medicines lawfully obtained without a doctor's prescription;
- Refills of any prescription in excess of the number of refills specified by the doctor, or any drugs or medicines dispensed more than one year following the date of the doctor's prescription order;
- Any quantity of drugs or medicines dispensed which exceed a thirty-four (34) day supply or one hundred (100) unit doses, whichever is greater, when taken in accordance with the directions of the prescriber, except if provided under the mail service program;
- Prescription drugs which may be properly received without charge under local, state or federal programs;
- Drugs labeled "Caution – limited by federal law to investigational use", or experimental drugs, even though a charge is made to the Covered Individual;
- Drugs prescribed for indications not approved by the Food and Drug Administration (FDA);
- Drugs or medicines in whole or in part, to be taken by, or administered to a Covered Individual during confinement in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution;
- Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substance, regardless of their intended use;
- Any charges for immunization agents, biological sera, blood or blood plasma, including the administration thereof;
- Any charges for contraceptives, contraceptive materials, contraceptive devices or infertility medications;
- A.D.D. / Narcolepsy medications for individuals twenty-four (24) years of age and older;
- Anabolic steroids;

- Anti-wrinkle agents (ie: Renova);
- Any drugs used for cosmetic purposes;
- Dermatologicals and hair stimulants;
- Erectile dysfunction medications;
- Fluoride supplements;
- Growth hormones;
- Hemantinics;
- Immunization agents, blood and blood plasma;
- Impotence medications;
- Interferon (Avonex);
- Isotretinoin (Accutane);
- Levonorgestrel (Norplant);
- Mineral and nutrient supplements;
- Non-legend drugs other than insulin;
- Pigmenting and depigmenting agents;
- Tretinoin topical (ie: Retin-A); and
- Vitamins, singly or in combination.

The following types of expenses require a 100% co-payment from the participant:

- Non-sedating antihistamines
  - Allegra, Clarinex, Zyrtec and any similar types

- Proton Pump Inhibitors
  - Aciphex, Nexium, Omeprazole, Prevacid, Prilosec, Protonix and any similar types

IMPORTANT NOTICE

Although the prescription drugs and medicines outlined in the Limitations may appear in the Prescription Benefit Managers listings of "Preferred Drugs" or "Primary Drugs", they are specifically excluded from coverage by the Plan.

Claims Procedures

Definition of a Claim

A claim is a request for Plan benefits made in accordance with the Plan's claims procedures. Should you be required to file the claim yourself, you will need to complete a Claim Form and attach an itemized statement from your provider which includes your name, identification number, the date of service, procedure code or description and diagnosis code.

When you go to a physician's office, hospital or any provider of medical services, you should present your medical identification card. The provider of services can use this ID card to contact the Fund Office and inquire as to your eligibility for coverage and the Plan's benefits.

In verifying eligibility and Plan benefits, the Fund Office staff will use the information which is currently available; however, this verification is not a guarantee of eligibility or benefits. When the Fund Office receives claims for benefits, the claims are processed in accordance with the Plan's provisions and the Fund's records regarding eligibility.

Assignment

In most cases, your physician's office, the hospital or provider of services will allow you to assign benefits so any payments made for expenses due to medical care and treatment by the Plan can be issued directly to the provider of services.

Submitting Claims

Your claim will be considered to have been filed as soon as it is received by the Fund Office. The Plan will accept a paper claim (mailed or delivered to the Fund Office) or an electronic claim.

The submission of a provider's claim to the provider's billing agent or clearinghouse does not constitute receipt of a claim by the Plan.

Timely Filing Limit

Your claim must be submitted within twelve (12) months of the date of service to be eligible for reimbursement under the Plan. Failure to submit a claim within the one year timely filing limit will result in the claim being denied with no benefits payable.

As a participant in the Plan, you are responsible for verifying the provider has submitted your claim. When your claim is processed by the Plan, both you and the provider will receive an Explanation of Benefits (also known as an EOB) explaining how the claim was processed.

Should a claim be submitted and not have the required information or documentation, both you and the provider will be notified that your claim has been received and is pending additional information or clarification before the benefit processing can be completed.

Payment of Claim

Payment of benefits will be made at regular intervals occurring at least once every thirty (30) days. When payment is made, you will receive an Explanation of Benefits (EOB) which will explain how the claim was processed. Included on this EOB is the provider's original charge, the allowable amount, any deductible amount and the Plan payment. This EOB will also show your member liability. You may receive a bill from the provider for any remaining balance, which will be your responsibility to pay. Should there be no member liability, you will also receive an EOB showing the allowable amount was paid in full. You should always retain all EOBs and notices from the Plan for your records.

If you pay an In-Network provider at the time of service, you may need to contact the provider about any refund should your member liability be less than your payment after the Plan processes your claim.

If your claim for benefits is denied, you have the right to file an appeal.

Not in Lieu of Workers' Compensation

The provisions of the Plan are not in lieu of, and shall not affect any requirements for coverage by Workers' Compensation insurance.

Plan Change or Termination

The Trustees reserve the right to change or discontinue the type and amounts of benefits under the Plan and the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Plan Benefits and eligibility rules for active, retired or disabled participants:

- Are not guaranteed;
- May be changed or discontinued by the Board of Trustees;

- Are subject to the rules and regulations adopted by the Board of Trustees;
- Are subject to the Trust Agreement which establishes and governs the Fund's operations; and
- Are subject to the provisions of any group insurance policy purchased by the Board of Trustees.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

If the Plan is changed or discontinued, it will not affect your or your beneficiary's right to any insured benefit to which you have already become entitled.

Benefit Appeal Procedures

Initial Claim Determination

Definitions

1. **Urgent claims** are requests for eligibility status or for medical care or treatment of an emergency nature, which could seriously jeopardize the life or health of the claimant or would subject the claimant to severe pain.

2. A **pre-service claim** is a request for eligibility status or for benefits for which a Plan requires pre-approval, such as predetermination of benefits for a major surgery.

3. A **post-service claim** is a request for a benefit following the claimant's receipt of services.

Time Limits

1. A decision with respect to an **urgent care** claim will be made within seventy-two (72) hours. If the claim is not complete, the Plan will notify you of the additional information required within twenty-four (24) hours.

2. A decision on a **pre-service claim** will be made within fifteen (15) days. The Plan will advise of a defective or incomplete filing of a pre-service claim within five (5) days of receipt. The Plan may take an additional fifteen (15) days, if it is determined an

extension is necessary due to matters beyond the control of the Plan and you are advised of the need for the extension.

3. A decision on **a post-service claim** will be made within thirty (30) days. The Plan will advise of a defective or incomplete filing of a post-service claim within thirty (30) days of receipt. You will have forty-five (45) days to provide the required information. The Plan may take an additional fifteen (15) days, if it is necessary due to matters beyond the control of the Plan and you are advised of the need for the extension.

Concurrent Care Decisions

1. If the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by the Plan or such course of treatment before the end of the period or number of treatments previously agreed will be considered a denial. The Plan will notify you of this action in advance of the application of the reduction or termination and advise of the appeal rights to permit a review prior to the date the benefit is reduced or terminated.

2. A decision with respect to extend the previously agreed to course of treatment for an urgent care claim will be acted upon as soon as possible. The Plan will notify you of the determination within twenty-four (24) hours of receipt, provided the claim is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

Claim Denial Procedures

If your claim is denied or partially denied, you will be notified in writing and provided an opportunity for a review.

The written notice of denial will provide:

1. The specific reason(s) for the denial;

2. The specific Plan provision on which the determination is based;

3. A description of additional information or information necessary for you to perfect the claim and an explanation of why this additional information is necessary;

4. A statement that the specific rule, guideline, protocol or other criterion relied upon in making the determination, if applicable, will be provided at no cost upon request;

5. A statement that an explanation of the scientific or clinical judgment relied upon and the names of the individuals from whom opinion(s) were secured, if a determination is based upon medical necessity or experimental treatment, or similar exclusion or limit, will be provided at no cost; and

6. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement regarding your right to bring a civil action under section 502(a) of ERISA.

Claim Review Procedures

Filing an Appeal

If your claim has either been denied or partially denied and you are not satisfied with the decision, you may appeal the decision and request a review of the claim. The appeal must include all of the following:

- Be in writing and can be made by you or your duly authorized representative;
- Should be mailed or delivered to the Fund address shown in the Summary Plan Description;
- Should state the reasons you believe the initial determination was incorrect;
- Should include any written comments, documents, records and other information relating to the claim for benefits; and
- Be submitted within one hundred eighty (180) days of the date you receive the notice of denial or partial denial.

You will be provided access to and copies of, at a reasonable charge, all documents, records, and other information relevant to your claim.

Decision on Review

- A decision on review of an urgent care claim will be made within seventy-two (72) hours after receipt of your request for review.

- A decision on review of a pre-service claim will be made within thirty (30) days of receipt of your request for review.
- A decision on review of a post-service claim will be made during the course of the regular quarterly Trustees' meeting following receipt of the request for review and you will be notified of the decision within five (5) days of the date of such meeting. (If the request for review is received within thirty (30) days of the next regular quarterly Trustees' meeting, the decision on review will be made no later than the date of the second meeting following the Plan's receipt of the request for review.) If special circumstances require an extension of time, a decision will be rendered no later than the next following quarterly Trustees' meeting. You will be advised of the special circumstances and the date the decision is expected to be made.

The decision of the Trustees on review will be made in good faith and will be final and binding on all issues. The claimant or claimant's duly authorized representative will be required to exhaust the entire claim review procedure before instituting any other form of action.

Life Insurance Benefit

If you die from any cause while you are insured, the proceeds will be paid to your beneficiary. The proceeds may be paid in monthly or annual installments or as a lump sum.

Beneficiary

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form. The change will be effective when the I.U.O.E. Local 132 Health and Welfare Fund receives the completed form at its office.

Conversion Privilege

If you are no longer eligible for group life insurance due to your ceasing to belong to an eligible insured class or if you terminate your employment, you may convert that benefit to any form of individual life insurance usually offered by the Insurance Company, except for term.

You will not need a medical examination, but you must complete the application form and send it with the first premium payment to the Insurance Company no later than thirty-one (31) days after your group life insurance has terminated.

The face value of your new policy cannot be more than the amount you had under the group plan. The rate you pay will depend upon your age (at the nearest birthday to the date of issue of the individual policy) and your class of risk at the time of your conversion.

You may also convert if your life insurance benefits terminate because the policy terminates, or because life insurance benefits for your class terminate. In this case, however, you must have been covered under the group plan for at least five (5) years. You may convert the lesser of the following amounts:

- The amount of life insurance you have under this Plan, less any new amount you may have or for which you may become eligible under another group plan within thirty-one (31) days of termination; or
- Two thousand dollars ($2,000)

If you should die during the thirty-one (31) day period after your group life insurance has terminated, the Insurance Company will pay the group life insurance benefits to the last beneficiary you named, whether or not you applied for an individual life insurance policy.

Accidental Death and Dismemberment Benefit (24 Hour Coverage)

This benefit will be payable if you, while insured, sustain any of the losses mentioned below as a result of purely accidental means. The loss must take place within ninety (90) days from the date of the accident for the benefits to be payable. This benefit is in addition to your other benefits under this Plan.

Who Will Receive Benefits

For loss of life, benefits will be paid to the beneficiary you name. For any other loss, the benefits will be paid to you.

Definitions

- Principal Sum is the benefit amount shown in the Schedule of Benefits.

- Loss of hand or foot means that the limb is severed at or above the wrist or ankle joint.
- Loss of sight means the total and irrecoverable loss of sight.

The Benefits

FOR LOSS OF:

Life	The Principal Sum
Two Hands	The Principal Sum
Two Feet	The Principal Sum
Sight of Two Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Hand and Sight of One Eye	The Principal Sum
One Foot and Sight of One Eye	The Principal Sum
One Hand or One Foot	One-half the Principal Sum
Sight of One Eye	One-half the Principal Sum

If you suffer more than one loss in any one accident, no more than the full amount of your benefit will be paid. The full amount is the principal sum.

Beneficiary

You may name anyone your wish as your beneficiary. You may change your beneficiary at any time by completing the proper form. The change will be effective when the form is received by the I.U.O.E. Local 132 Health and Welfare Fund at its office.

Losses that are Not Covered

No benefit is payable under this section if your death or any loss is caused directly or indirectly, in whole or in part, by:

- Bodily or mental illness or disease of any kind;
- Ptomaines or bacterial infection (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
- Suicide or intentional self-inflicted injury;
- Participation in the commission of a felony; or
- Any act of war, whether declared or undeclared.

Dependents' Life Insurance Benefits

Life insurance is provided for your eligible dependents in the amounts shown in the Schedule of Benefits. If one of your dependents dies, the

life insurance proceeds will be payable to you. However, if you die before your dependent, you dependent's life insurance proceeds will be payable upon his death to the executor or administrator of the estate or, at the Company's option, to any one or more of his or her surviving relatives; mother, father, child or children, brothers or sisters.

Effective Date of Dependents' Life Insurance

Coverage for your dependents starts on the date your coverage starts or, if your coverage is already in effect, on the date he acquires the status of an eligible dependent.

Termination of Dependents' Life Insurance

The dependents' life insurance shall terminate on the earliest of the following:

- The date your insurance as an employee terminates;
- The date a change is made in the Plan to terminate dependents' coverage; or
- The date a dependent is no longer an eligible dependent, as defined above.

Exception: If your dependents' life insurance would otherwise terminate due to your death, such dependent will continue to be eligible for the rest of the Benefit Quarter for which you would have been otherwise eligible.

Conversion Privilege

If your dependents' life insurance terminates because your coverage terminates or because his eligibility terminates, he may convert that benefit to any form of life insurance, except term, usually offered by the Company.

A medical examination will not be required. However, the application form and the first premium payments must be sent to the Company no later than thirty-one (31) days after the life insurance coverage has terminated.

The face value of the new policy cannot be more than the amount under the group plan. The rate charged will depend upon your Dependents' age and class of risk at the time of conversion.

The converted policy will become effective on the thirty-second (32) day following the date his or her life insurance coverage terminated.

Your dependent may also convert if his life insurance benefits terminate because the policy terminates, or because life insurance benefits or dependent status terminates. In this case, however, he must have been covered under the group plan for at least three (3) years. He may convert the lesser of the following amounts:

- The amount of life insurance he had under this Plan, less any amount of group life insurance for which he may become eligible under a group plan issued or reinstated within thirty-one (31) days of such termination; or
- Two thousand dollars ($2,000)

If your dependent dies during the thirty-one (31) day period after his group life insurance terminated, the Company will pay the life insurance benefit, as specified in the provision, whether or not your dependent had applied for an individual life insurance conversion policy.

General Provisions

How to Appeal a Life Insurance Claim

If you do not agree with a claim denial, you may request that a review be made of your claim. The claim denial will tell you the name and address of the person to whom you may send a written request.

You may submit additional information with your request for review. You may request and receive copies of pertinent documents, although in some cases approval may be needed for the release of confidential information, such as medical records. You may submit issues and comments in writing.

A decision will be made within sixty (60) days following the date the Insurance Company received your request for review or the date the Insurance Company received all information required of you, whichever date is later. You will be notified of the decision in writing and you will be given clear and specific reasons for the decision.

Facility of Payment

If you or your Dependent are not legally capable of giving a valid receipt for a benefit payment, the Insurance Company has the right (if there is no legal guardian) to pay the party it believes is entitled to such payment. Once such a payment is made, the Insurance Company has no further obligation with respect to the amount so paid. If you name more than one (1) Beneficiary, but do not say how much each Beneficiary should

receive, the total amount will be shared equally by all surviving Beneficiaries. If there is no living Beneficiary when you die, the Insurance Company will make the payment to your spouse; if none, to your children; if none, to your parents; if none, to your brothers and sisters. However, the Insurance Company has the option to make the payment to your estate.

Examinations

The Insurance Company shall have the right and opportunity through its medical representative to examine any living insured during the pendency of a claim and so often as it may reasonably require.

The Insurance Company shall also have the right to make an autopsy in the case of death, where it is not forbidden by law.

Legal Actions

No action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty (60) days after written Proof of Loss has been furnished. No action shall be brought after the expiration of three (3) years from the time Proof of Loss is required.

Change of Beneficiary

The right to change of beneficiary is reserved to the insured. The consent of the beneficiary or beneficiaries is not required for any change in beneficiary requested by the insured.

Conformity with State Laws

Where required by law, limitations will be extended to comply with the minimum requirements of the state in which the insured resides or works.

Key Terms and Definitions

These are some of the terms used in your booklet. Some other terms are described where they are used. Please read them carefully. It can help you better understand your benefits.

Gender, whenever a personal pronoun in the masculine gender is used, it includes the feminine, unless the context clearly indicates otherwise.

"**Covered Charges**" means the reasonable and customary charges which are incurred for the medically necessary treatment of conditions that are covered under the Plan.

"**Day of Hospital Confinement**" means a period of twenty-four (24) hours or less for which the hospital makes a full daily room and board charge.

"**Dependent**" means your spouse and each of your children less than twenty-six (26) years of age.

"**Child**" includes the following:

- Your biological child;
- A legally adopted child, including a child placed with you for the duration of the probationary period, without regard to whether the adoption becomes final;
- A stepchild residing with you for whom you provide sole support (evidenced by federal income tax returns) where the applicable divorce decree does not obligate the other biological or legal parent to provide health care or health insurance coverage;
- A child permanently residing in your household for whom you provide sole support, provided you are related to the child by blood or marriage and you have been granted legal custody by a court of record; and
- Any child named in a Qualified Medical Child Support order satisfying all of the conditions outlined in the Omnibus Budget Reconciliation Act of 1993.

  While your Dependent Coverage is in effect, newly acquired dependents automatically become Covered Individuals on the date they meet this definition of "dependent", subject to the effective date. If you die, the eligibility of your dependents shall continue to the end of the normal termination date, as outlined in "Termination of Coverage".

"**Dependent Coverage**" means coverage under the Plan with respect to your dependents.

"Fund" means the International Union of Operating Engineers Local 132 Health and Welfare Fund.

"**Hospital**" means an institution which:

- Is primarily engaged in providing, by or under the supervision of Physicians, inpatient diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or rehabilitation of injured, disabled or sick persons;
- Maintains clinical records on all patients;
- Has bylaws in effect with respect to its staff of Physicians;
- Has a requirement that every patient be under the care of a Physician;
- Provides twenty-four (24) hour nursing service rendered or supervised by a registered professional nurse;
- Has in effect a hospital utilization review plan;
- Is licensed pursuant to any state or agency of the state responsible for licensing Hospitals; and
- Has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

"**Hospital**" does not mean any institution, or part thereof, which is used principally as a rest facility, nursing facility, convalescent facility or facility for the aged. It does not mean any institution that makes a charge that you or your dependents are not required to pay. However, the term shall include any rehabilitative facility which is licensed by the state for the treatment of alcoholism or drug abuse.

"**Illness**" means a bodily sickness, disorder or disease. All such conditions existing concurrently or successively which are due to the same or related cause shall be considered as an illness. The Plan treats pregnancy as if it were an illness for you or your eligible dependents.

"**Injury**" means all damage to you or your eligible dependent's body which is caused by an accident while this Plan is in force and which results directly and independently of all other causes in a loss covered under this Plan.

"**Inpatient**" is a covered individual who incurs a hospital charge for a day of hospital confinement in other than the outpatient department of the hospital.

"**Medically Necessary**" means the services, supplies, treatment and confinement must be generally recognized in the physician's profession as effective and essential for the treatment of the injury or illness for which it is ordered and that they must be rendered at the appropriate level of care in the most appropriate setting based on diagnosis. To be considered "Medically Necessary", the care must be based on generally recognized and accepted standards of medical practice in the United States and it must be the type of care that could not have been omitted without an adverse effect on the patient's condition or the quality of medical care. In addition, services, treatment, supplies or confinement shall not be considered "Medically Necessary" if they are an experimental procedure, or if investigational or primarily limited to research in their application to the injury or illness; or if primarily for the comfort, convenience or administrative ease of the provider or the patient or his or her family or caretaker.

The definition and determination of Medically Necessary shall not apply to any services which are covered under the Plan as preventive services. Preventive services means those services and supplies used for routine physical examinations and any such other services which are not for the treatment of an injury or illness, but which are for prevention of disease and for maintenance of good health which may otherwise be covered under the Plan.

"**Participant Coverage**" means coverage under the Plan with respect to yourself.

"**Physician**" means a duly licensed doctor of medicine authorized to perform medical or surgical service within a lawful scope of his practice, and shall also include any other health care provider or allied practitioner as mandated by State Law.

"Plan" means the International Union of Operating Engineers Local 132 Health and Welfare Fund.

"**Totally Disabled**" when used in reference to the Health coverage means, with respect to you, that you, due solely to Injury or Illness, are prevented from engaging in your regular or customary occupation and you receive no remuneration for any other work or service. With respect to a dependent, this means that he, due solely to Injury or Illness, is prevented from engaging in substantially all of the normal activities of a person of like age and like sex who is in good health. This definition does not apply to Life Insurance.

“**Reasonable and Customary**” means the usual charge made by a person, a group or an entity which renders or furnishes the services, treatment or supplies that are covered under this Plan. In no event does it mean a charge in excess of the general level of charges made by others who render or furnish such services, treatments or supplies to persons: (a) who reside in the same area and (b) whose illness is comparable in nature and severity. The term “area” means a county or such greater area that is necessary to obtain a representative cross section of the usual charges made.

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

This Notice of Privacy Practices describes how protected health information may be used or disclosed by your Group Health Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your protected health information, and describes your rights to access and control your protected health information.

Protected Health Information (or "PHI") is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices had been drafted to be consistent with what is known as the "HIPAA Privacy Rule", and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact Jerry Moore, Fund Office Manager, I.U.O.E. Local 132 Health & Welfare Fund, 636 Fourth Avenue, Huntington, West Virginia 25701-1321.

Effective Date

This Notice of Privacy Practices became effective on April 14, 2003.

Our Responsibilities

We are required by law to maintain the privacy of your protected health information. We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to protected health information, and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all protected health information that we

maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the contract holder for your member contract.

Primary Uses and Disclosures of Protected Health Information

The following is a description of how we are most likely to use and/or disclose your protected health information.

1. **Payment and Health Care Operations**
   We have the right to use and disclose your protected health information for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

2. **Payment**
   We will use or disclose your protected health information to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your protected health information when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

3. **Health Care Operations**
   We will use or disclose your protected health information to support our business functions. These functions include, but are not limited to quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your protected health information: (i) to provide you with information about one of our disease management programs; (ii) to respond to a customer service inquiry from you; (iii) in connection with fraud and abuse detection and compliance programs.

4. **Business Associates**
   We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide services, our Business Associates will receive, create, maintain,

use, or disclose protected health information, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our Prescription Benefit Manager, Caremark, our utilization review firm, AliCare, our Preferred Provider Organization, 4 Most Health Network, etc.

5. **Other Covered Entities**
   We may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your protected health information with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

6. **Plan Sponsor**
   We may disclose your protected health information to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law

The HIPAA Privacy Regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

Other Possible Uses and Disclosures of Protected Health Information

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your protected health information.

1. **Required by Law**
   We may use or disclose your protected health information to the extent that federal law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your protected health information when required by national security laws or public health disclosure law.

2. **Public Health Activities**
   We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose protected health information, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

3. **Health Oversight Activities**
   We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) health care systems; (ii) government benefit programs; (iii) other government regulatory programs; (iv) compliance with civil rights laws.

4. **Abuse or Neglect**
   We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information if we believe that you have been a victim of abuse, neglect, or domestic violence.

5. Legal Proceedings

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discover request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

6. Law Enforcement

Under certain conditions we may also disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (3) it is necessary to provide evidence of a crime that occurred on our premises.

7. Coroners, Medical Examiners, Funeral Directors, and Organ Donation

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

8. Research

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

9. To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is

necessary for law enforcement authorities to identify or apprehend an individual.

10. **Military Activity and National Security, Protective Services**
    Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

11. **Inmates**
    If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

12. **Worker's Compensation**
    We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

13. **Others Involved in Your Health Care**
    Using our best judgment, we may make your protected health information known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

    We may also disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

    If you are not present or able to agree to these disclosures of your protected health information, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make.

1. **Disclosures to the Secretary of the U.S. Department of Health and Human Services**
   We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

2. **Disclosures to you**
   We are required to disclose to you most of your protected health information in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your protected health information that are for reasons other than payment and health care operation and are not disclosed through a signed authorization.

We will disclose your protected health information to an individual who has been designated by you as your personal representative upon submission of a written notice of his/her designation, along with the documentation that supports his/her qualification (such as power of attorney). We will recognize certain individuals as personal representatives without completion and submission of a representative form. For example, we will recognize spouses covered under the plan as personal representatives for each other. Likewise, a covered parent or guardian will be considered a representative of a covered dependent.

Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

Other Uses and Disclosures of Your Protected Health Information

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

Your Rights

The following is a description of your rights with respect to your protected health information.

1. **Right to Request a Restriction**
   You have the right to request a restriction on the protected health information we use or disclose about you for payment or health care operations.

   We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

   You may request a restriction by writing to Jerry Moore, Fund Office Manager, I.U.O.E. Local 132 Health & Welfare Fund, 636 Fourth Avenue, Huntington, West Virginia 25701-1321. It is important that you direct your request for restriction to this address so that we may begin to process your request. Requests sent to persons or offices other than the address indicated might delay processing the request.

   We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

2. **Right to Request Confidential Communications**
   If you believe a disclosure of all or part of your protected health information may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example,

you may ask that we only contact you at your work address or via your work email.

You may request a restriction by writing us in care of Jerry Moore, Fund Office Manager, I.U.O.E. Local 132, 636 Fourth Avenue, Huntington, West Virginia 25701-1321. It is important that you direct your request for confidential communication to this address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) that you want us to communicate your protected health information with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your protected health information could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternative arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (ie: an EOB). Unless you have made other payment arrangements, the EOB (in which your protected health information might be included) will be released to the plan participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within two (2) business days.

Prior to receiving the information necessary for this request, or during the time it takes to process it, protected health information may be disclosed (such as through an Explanation of Benefits, "EOB"). Therefore, it is extremely important that you contact us as soon as you determine that you need to restrict disclosures of your protected health information.

If you terminate your request for confidential communications, the restriction will be removed for all your protected health information that we hold, including protected health information that was previously protected. Therefore, you should not terminate a request for confidential communication if you remain concerned that disclosure of your protected health information will endanger you.

3. Right to Inspect and Copy

You have the right to inspect and copy your protected health information that is contained in a "designated record set". Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your protected health information contained in a designated record set, you must submit your request by calling us. Requests sent to persons, offices, other than the one indicated might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact us. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

4. Right to Amend

If you believe that your protected health information is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by writing to Jerry Moore, Fund Office Manager, 636 Fourth Avenue, Huntington, West Virginia 25701-1321. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to this address so that we can begin to process your request. Requests sent to persons or offices, other than the one indicated might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

5. Right of an Accounting

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of protected health information will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to Jerry Moore, Fund Office Manager, I.U.O.E. Local 132 Health & Welfare Fund, 636 Fourth Avenue, Huntington, West Virginia 25701-1321. It is important that you direct your request for an accounting to this address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

Your request may be for disclosures made up to six (6) years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

6. Right to a Paper Copy of This Notice

You have a right to a paper copy of this Notice, even if you have agreed to accept this notice electronically.

Complaints

You may complain to us if you believe that we have violated your privacy rights. A copy of a complaint form is available from this office.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

Rights and Protections Under ERISA

As a Participant in the Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

2. Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

3. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of the summary annual report.

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

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

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

If you have any questions about your plan, you should contact the plan administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Important Information Required by ERISA

Name of the Plan: International Union of Operating Engineers Local 132 Health and Welfare Fund

Union: International Union of Operating Engineers Local 132, AFL-CIO

Trust Identification Number of the Plan: 55-0455491 **Plan Number**: 501

Plan Administrator: The Plan is administered by the Board of Trustees (the "Trustees") appointed by the Union and the Employers who have signed the Collective Bargaining Agreement.

Trustees of the I.U.O.E. Local 132
Health and Welfare Fund
636 Fourth Avenue, 2nd Floor
Huntington, WV 25701-1321

Trustees of the Plan: The Trustees hold Plan assets and issue benefit payments. The Trustees are as follows:

Union Trustees	**Employer Trustees**
Tommy G. Plymale, Secretary I.U.O.E. Local 132 AFL-CIO 606 Tennessee Avenue Charleston, WV 25362-0770	Al J. Schurman, Chairman 4184 Brittany Lane Sarasota, FL 34233-3703
Rodney Marsh I.U.O.E. Local 132 AFL-CIO 2310 South Fayette Street Beckley, WV 25801-6935	D.W. "Bud" Daniel, Jr. Wayne Concrete Company, Inc. P.O. Box 342 Barboursville, WV 25504-0342

Legal Counsel: Lawrence B. Lowry
Barrett, Chafin, Lowry & Amos
636 Fourth Avenue, 2nd Floor
Huntington, WV 25701-1321
Phone: (304) 529-2434

Legal process may be served upon one or more Trustees.

Better Understand Your Health

Taking an active role in your own medical treatment may be one of the most important decisions of your life. It is essential for patients and doctors to be partners in health care and a good partnership with your doctor begins with open communication.

The American Society of Internal Medicine estimates that 70% of a correct diagnosis depends on what the patient tells their doctor. Simply making a list of questions before an office visit will improve communication by helping you to organize your thoughts and your doctor to clearly understand your concerns.

There are a variety of health providers that treat patients, so you should know which professionals offer the best care for a specific problem. Following are brief definitions for some of the medical professionals:

Doctors of Medicine (MD)

Doctors of Medicine use all acceptable methods of medical care to treat diseases and injuries, provide preventive care, do checkups, prescribe drugs and perform some surgeries. An MD must be licensed by the state where they practice.

Doctors of Osteopathic Medicine (DO)

Doctors of Osteopathic Medicine receive training similar to MDs and provide general health care to individuals and families. They may treat patients with drugs, surgery and other types of treatments, along with treating problems of muscles, bones and joints.

Family Practitioners

Family Practitioners are MDs or DOs who specialize in providing comprehensive, continuous health care for all family members, regardless of age or sex.

Internists (MD or DO)

Internists specialize in the diagnosis and treatment of diseases in adults.

Surgeons

Surgeons treat diseases, injuries and deformities by operating. A general surgeon can perform many common operations, but many specialize in one area of the body. Neurosurgeons treat disorders relating to the nervous system, spinal cord and brain. An orthopedic

surgeon treats disorders of the bones, joints, muscles, ligaments and tendons. A thoracic surgeon treats disorders of the chest.

Physicians may refer patients to a specialist, such as:

Cardiologist	heart specialist
Dermatologist	skin specialist
Endocrinologist	specialist in disorders of glands of internal secretion
Gastroenterologist	specialist in diseases of the digestive tract
Gynecologist	specialist in the female reproductive system
Hematologist	specialist in disorders of the blood
Nephrologist	specialist in the function and disease of the kidneys
Neurologist	specialist in disorders of the nervous system
Oncologist	specialist in cancer
Otolaryngologist	specialist in diseases of the ear, nose and throat
Physiatrist	specialist in physician medicine and rehabilitation
Psychiatrist	specialist in mental, emotional and behavioral disorders
Pulmonary specialist	physician who treats disorders of the lungs and chest
Rheumatologist	specialist in arthritis and rheumatism
Urologist	specialist in the urinary system for both males and females and the male reproductive system

Opthalmologists (MD or DO)

Opthalmologists diagnose and treat eye diseases and can prescribe drugs, perform surgery and often treat older people who have glaucoma and cataracts. They may also prescribe eyeglasses or contact lenses.

Physician Assistants (PA)

Physician Assistants usually work in a hospital or doctor's offices and do some of the tasks traditionally performed by doctors, such as taking medical histories and doing physical examinations. A Physician Assistant must always be under the supervision of a doctor.

Psychiatrists (MD or DO)

Psychiatrists treat people with mental and emotional difficulties. They can prescribe medication, counsel patients and perform diagnostic tests.

Psychologists (PhD, PsyD, EdD or MA)

Psychologists are trained and licensed to assess, diagnose, and treat people with mental, emotional or behavioral disorders. They can counsel people through individual, group or family therapy.

REHABILITATIVE CARE

Physical Therapists (PT)

Physical Therapists help people whose strength, ability to move, or sensation is impaired. They may use exercise, heat, cold or water therapy, or other treatments to control pain, strengthen muscles and improve coordination. Patients are usually referred to a physical therapist by a doctor.

Occupational Therapists (OT)

Occupational Therapists assist those who have lost function due to an accident, illness or other disability and help restore independence in general daily activities through exercises designed to improve function.

NURSING CARE

Registered Nurses (RN)

Registered Nurses work in hospitals, doctor's offices, clinics and community health clinics and administer treatments, give medicine and educate patients.

Nurse Practitioners (RN or NP)

Nurse Practitioners are trained beyond nursing education and perform physical exams and diagnostic tests, counsel patients and develop treatment programs. They may work independently or be staff members at hospitals or health care facilities.

Case Manager

A Case Manager is a Registered Nurse who coordinates quality healthcare for the patient. The Case Manager plans with the patient, family, physicians and the rest of the healthcare team members to facilitate positive outcomes. Coordination continues throughout the hospital stay including any activities needed to assist with the discharge planning process whether that would be to the home or to another facility for the continued care.

Helpful Contacts and Resources

Listed below are associations and foundations which are excellent sources for additional information.

Administration on Aging	1-202-619-0724 http://aoa.gov
Alzheimer's Association	1-800-272-3900 www.alz.org
American Academy of Dermatology	1-888-462-DERM http://aad.org
American Cancer Society	1-800-ACS-2345 www.cancer.org
American Diabetes Association	1-800-232-3472 www.diabetes.org
American Dietetic Association	1-800-877-1600 www.eatright.org
American Heart Association	1-800-242-9236 www.americanheart.org
American Kidney Fund	1-800-638-8299 www.kidneyfund.org
American Liver Foundation	1-800-223-0179 www.liverfoundation.org
American Lung Foundation	1-800-LUNG-USA www.lungusa.org
American Thyroid Association	1-800-THYROID www.thyroid.org
Arthritis Foundation	1-800-283-7800 www.arthritis.org
Asthma & Allergy Foundation of America	1-800-7-ASTHMA www.aafa.org

Brain Injury Association	1-800-444-6443 www.biausa.org
Centers of Disease Control and Prevention	1-800-311-3435 www.cdc.gov
Center for the Partially Sighted	1-800-481-3937 www.low-vision.org
Elder Care Locator	1-800-677-1116 www.eldercare.gov
Epilepsy Foundation of America	1-800-EFA-4050 www.efa.org
Glaucoma Research Foundation	1-800-826-6693 www.glaucoma.org
International Hearing Society	1-800-521-5247 www.ihsinfo.org
Lupus Foundation of America	1-888-38LUPUS www.lupus.org
Medic Alert Foundation	1-800-432-5378 www.medicalert.org
Medicare Hotline	1-800-MEDICARE www.medicare.gov
Muscular Dystrophy Association	1-800-572-1717 www.mdausa.org
National Cancer Institute	1-800-422-6237 www.cancer.gov
National Council on Aging	1-800-424-9046 www.ncoa.org
National Hospice Organization	1-800-658-8898 www.nhpco.org
National Stroke Association	1-800-787-6537 www.stroke.org

Contact and Resource Notes

Personal Health History

Name

Home address

Home phone

SSN or ID Number

Medicare Number

Personal Physician

Address

Phone

Personal Physician

Address

Phone

Emergency Contact 1

Name Relationship

Address

Phone

Emergency Contact 2

Name Relationship

Address

Phone

Personal Health History

Name

Date of Birth Blood Type

Height Weight Blood Pressure

Allergies

Vaccination Record

Pneumonia Vaccine ☐ Yes ☐ No Date

DT Diphtheria/Tetanus ☐ Yes ☐ No Date

Influenza ☐ Yes ☐ No Date

List other vaccinations and dates

Medical History

Date	Condition/Diagnosis

Personal Health History

Surgical History

Date	Condition/Diagnosis

Dental History

Date	Condition/Diagnosis

Family Health History

List any serious health problems among your parents, siblings, grandparents, blood related aunts and uncles and your spouse.

Name Relationship

Health Problems

If deceased, list age at death

Cause of death

Name Relationship

Health Problems

If deceased, list age at death

Cause of death

Name Relationship

Health Problems

If deceased, list age at death

Cause of death

Office Visit Notes

Physician Date

Blood Pressure Weight

Reason for Visit

Summary / Action

Physician Date

Blood Pressure Weight

Reason for Visit

Summary / Action

Physician Date

Blood Pressure Weight

Reason for Visit

Summary / Action

Physician Date

Blood Pressure Weight

Reason for Visit

Summary / Action

Office Visit Notes

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Summary / Action

Physician Date

Blood Pressure Weight

Reason for Visit

Summary / Action

Notes

Your continued eligibility for benefits will cease immediately if you become employed without the Union's consent by an Employer who is not required to make contributions to the Fund in a category of employment for which other Employers make contributions to the Fund or if you become employed outside the Fund's jurisdiction by any Employer for whom you perform work commensurate with that considered to be in the same industry, trade or craft as you performed while working in this Fund's jurisdiction.

Taking an active role in your own medical treatment may be one of the most important decisions of your life…

◊◊◊

Never be afraid to ask questions about your health care.