

**International Union  
of  
Operating Engineers  
Local 132**

**MY  
Health**

**Taking  
an active  
role...**

**Health and Welfare Fund  
Summary Plan Description**

**2019 Edition**

## **Contacting the Fund Office**

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636 Fourth Avenue  
Huntington, West Virginia 25701-0067

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This summary is available for you online at

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### **GOVERNING LAW**

All questions pertaining to the validity or interpretation of the Trustee Agreement, the Plan, or any questions concerning the acts and transactions of the Trustees or any other matter that affects the Plan will be determined under federal law, where applicable federal law exists. If there is no applicable federal law, the laws of the state of West Virginia will apply in all matters.

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# Introduction

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## 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 1<sup>st</sup> and ends on June 30<sup>th</sup>, 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

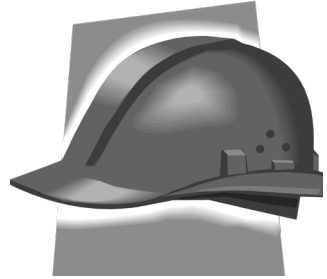
The Trustees are empowered to amend the Plan and the benefits provided hereunder from time to time as they in their sole discretion determine appropriate. Participants will be advised of any material modification to the Plan by notice forwarded to their last known address by first class mail, postage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

## Contacting the Fund Office

**Physical Address** I.U.O.E. Local 132 Trust Office  
636 Fourth Avenue  
Huntington, West Virginia 25701-0067

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# Your Health and Welfare Benefits

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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

<b>Annual Deductible</b>	Individual Family	\$250 \$500
<b>Maximum Out of Pocket Expense</b>	Annual	\$3,000 to \$6,000
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)		
<b>Dental/Vision Care Benefit</b>	Maximum Reimbursement 100% Payment Factor	\$750
<b>Pediatric Dental/Vision Care</b>	The first \$750 is reimbursed at 100%, 50% reimbursement factor thereafter.	
<b>Preventive Care Benefit</b>	The first \$1,000 is reimbursed at 100%, then a 50% reimbursement factor thereafter.	

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

<b>Benefit and Payment Factors</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<p><b>Radiology Services</b> X-Rays, MRIs, MRAs, CAT scans and PET scans (billed through independent facility)</p>	85% of allowable charge	70%
<p><b>Chiropractic Treatment</b> Limited to twenty (20) visits or a maximum of \$1,000 per calendar year (including x-rays)</p>	85% of allowable charge	70%
<p><b>Physical Therapy</b> Limited to a 20 visits per condition per calendar year and must be medically necessary and not for developmental or educational expenses</p> <p><b>Speech Therapy</b> Limited to 24 visits per condition per calendar year; up to a max of 48 visits</p>	85% of allowable charge	70%
<p><b>Alcohol and Substance Abuse Treatment</b></p>	85% of allowable charge	70%
<p><b>Mental Health Care Treatment</b> Inpatient Expenses</p>	85% of allowable charge	70%
<p><b>Mental Health Care Treatment</b> Outpatient Expenses Limited to one (1) visit per day and fifty-two (52) visits per calendar year</p>	85% of allowable charge	70%
<p><b>Maternity Care</b> Physician charges All prenatal and postnatal visits</p> <p>Delivery charges</p>	85% of allowable charge  see hospital inpatient	70%  see hospital inpatient

## Prescription Drug Benefits

<b>Annual Deductible</b>	\$100 per individual
<b>At the Pharmacy</b>  30 Day Supply per fill of a prescription	<b>GENERIC</b> You pay greater of \$7.50 or 10% of the cost
	<b>Preferred BRAND NAME</b> You pay the greater of \$20 or 20% of the cost
	<b>Non-Preferred BRAND NAME</b> You pay the greater of \$35 or 30% of the cost
	The maximum co-payment for any one (1) prescription is \$100.
<b>Mail Order Program</b>  90 Day Supply per fill of a prescription	<b>GENERIC</b> \$20.00 per prescription
	<b>Preferred BRAND NAME</b> \$40.00 per prescription
	<b>Non-Preferred BRAND NAME</b> \$80.00 per prescription
Please refer to the Prescription Benefit Managers booklet for a listing of the Preferred Brand Name Drugs.	
<p><b><i>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.</i></b></p>	

## Life Insurance Benefits

<b>Participant</b>	
Life Insurance	\$25,000
Accidental Death & Dismemberment (AD&D)	\$25,000
<b>Dismemberment and Loss of Sight</b>	
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
<b>Dependents</b>	
Spouse	\$10,000
Children	\$5,000
24 hours after live delivery but less than 19 years of age (to age 23 if continuing to meet the dependent definition)	
The Life Insurance, AD & D and Dependent Life Insurance Benefits are underwritten by an insurance company.	

## Weekly Disability Benefit

<b>Weekly Disability Benefit</b>	\$350
Waiting Period for Injury	0 days
Waiting Period for Illness	7 days
Maximum Benefit Period	26 weeks
<p>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.</p> <p>The weekly disability benefit is for active participants only and does not apply to a retiree, spouse or an eligible dependent.</p>	

# Eligibility

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## 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 February 28 (29) March 31 April 30 May 31 June 30 July 31 August 31 September 30 October 31 November 30 December 31	March and April April May, June and July June and July July August, September and October September and October October November, December and January December and January January 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 1<sup>st</sup> For coverage February 1<sup>st</sup> through April 30<sup>th</sup>
- May 1<sup>st</sup> For coverage from May 1<sup>st</sup> through July 31<sup>st</sup>
- August 1<sup>st</sup> For coverage from August 1<sup>st</sup> through October 31<sup>st</sup>
- November 1<sup>st</sup> For coverage from November 1<sup>st</sup> through January 31<sup>st</sup>

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

<b>Benefit Quarter Beginning</b>	<b>Work Quarters</b>
February 1 <sup>st</sup>	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 1 <sup>st</sup>	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 1 <sup>st</sup>	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 1 <sup>st</sup>	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:

- The plan without a Coordination of Benefits provision will always pay as primary.
- 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, benefit determination is applied in the following order:

- The plan of the custodial parent;
- The plan of the custodial parent's new spouse (if remarried);
- The plan of the non-custodial parent;
- The plan of the non-custodial parent's new spouse (if remarried).

If none of the above situations apply, the plan covering the child the longest 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 (62<sup>nd</sup>) 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

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## Continuation of Group Medical Benefits

You may elect to continue medical benefits for yourself and your eligible dependents for up to eighteen (18) months from the date your eligibility ends as a result of:

- Termination of employment (other than due to gross misconduct);  
or
- You do not satisfy the hours requirement to qualify for benefits.

You may elect to continue your benefits for an additional eleven (11) month period beyond the basic eighteen (18) month period if you are awarded Social Security Disability Benefits as the result of a disability which commenced prior to the qualifying event or within sixty (60) days of the commencement of the COBRA continuance. Proof of the total disability must be provided to the Fund Office prior to the end of the basic eighteen (18) month period.

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:

- You die;
- You become entitled to Medicare benefits;
- You and your spouse are legally separated or divorced; or
- A child is no longer an eligible dependent

You are responsible for notifying the Fund Office in writing when medical benefits end in accordance with any of the above. This notice must be received by the Fund Office within sixty (60) days after the divorce, legal separation, or dependent's loss of eligibility. You will need to provide a copy of any court order, birth certificate, or other information the Plan may deem relevant. Additionally, if you are already receiving COBRA continuation coverage, you must notify the Fund Office, in writing, of any qualifying event that may extend your COBRA eligibility period.

When the qualifying event is the end of employment or reduction of the participant's hours for maintaining eligibility and the participant became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until thirty-six (36) months after the date of

the Medicare entitlement. For example, if a covered participant becomes entitled to Medicare eight (8) months before the date on which his eligibility lapses, COBRA continuation coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (36 months minus 8 months).

If your family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the participant or former participant dies, becomes entitled to Medicare benefits \*under Part A, Part B, or both), gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Upon recognition of the occurrence of a qualifying event, the Fund Office will send you and your spouse a notice describing your rights to purchase continued benefits. (The notice will be sent to a former dependent if the qualifying event resulted in the loss of dependent eligibility.) You or your dependents have sixty (60) days to return the written application for COBRA continuation coverage. This sixty (60) day period begins on the latter of:

- The date benefits would otherwise end (the last day of the Benefit Month); or
- The date the notice is received, if the notice is sent after the last day of the Benefit Month.

The required contribution for purchase of the continue coverage must be paid to the Fund within forty-five (45) days from the date the COBRA continuation is elected. The notice of your rights to COBRA will provide the costs associated with the options available. This initial payment must include the current month's premium plus any premium due for the months which have elapsed since the end of the last Benefit Quarter for which you or your dependents were eligible. Subsequent payment are due monthly of the first day of the month. A thirty (30) day grace period is granted to payment of the amount due.



The COBRA continuance coverage will end at the earliest of the following to occur:

- The day any required premium is not paid on time;
- The day the Fund ceases to provide any group health plan;
- The day you or your covered dependent(s) becomes entitled to Medicare (except that if a covered employee becomes entitled to Medicare, his or her coverage family members may continue coverage for up to 36 months from the date of the initial qualifying event); or
- The day you or your covered dependent(s) become covered under another group health plan, as an employee or otherwise. If you or a covered dependent has a pre-existing condition that is not covered under the other plan due to a pre-existing conditions limitation clause, you may continue coverage under this Plan until the end of the maximum continuation period, except if such clause does not apply to you (or if you satisfy it) or a covered dependent because of the provisions of the Health Insurance Portability Act of 1996 (HIPAA) or the ACA; or
- The day you or your covered dependent(s) again become covered under the Plan;
- The date the Social Security Disability Award is revoked (which entitled the person to continue coverage beyond the eighteen (18) month continuance period); or
- The first of the month for which the premium payment is rejected by that person's bank for insufficient funds.

In the event more than one (1) continuation provision applies, the periods of COBRA continuance 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.

You, or your dependents WILL NOT receive monthly reminder notices concerning payment of the required premium to keep coverage in effect. It is the responsibility of the covered individual to pay the premium when due.

This is not a complete description of your COBRA rights. For more information you can contact the Fund Office at 1-800-642-3525 or (304) 525-0482, or you can review the Department of Labor website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

# Comprehensive Major Medical Benefits

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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.

## Calendar Year 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.

# Eligible Medical Expenses

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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.

Shingles Vaccination coverage has been added for the Medicare Supplemental eligible participants at a maximum of \$300 paid at 80%, which is the same percentage used by the Fund in the processing of Medicare deductibles and co-payments. In regards to the Active and Early Retiree eligible participants, the Shingles Vaccination continues to be included with your Preventive Care benefit.

## **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.

## Dental / Vision Care Benefit

If while covered, you or an eligible dependent incur expenses for dental 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 \$750 for expenses incurred in a calendar year.



In regards to pediatric dental/vision care, if an eligible minor children, 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 \$750, then 50% thereafter.

Please note, Orthodontics are not considered as an “essential health benefit”, and are not covered under the Dental 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-four (24) visits. Additional visits may be permitted after the review of therapist's documentation and progression. Speech therapy is limited to a maximum of forty-eight (48) 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.



# IMPORTANT NOTICES

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## **Women's Health & Cancer Rights Act**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complication of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, you can call the Trust Office at (304) 525-0482 or toll-free at 1-800-642-3525.

## **Newborn's and Mother's Health Protection Act**

Group Health Plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours, following a Cesarean section. However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) or ninety-six (96) hours, as applicable. In any case, plans and insurers may not require that a provider obtain authorization from the plan or insurer for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours, as applicable.

## **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 provided coverage for services performed by an out-of-network residential treatment facility and this exclusion would include, but not limited to, services for inpatient or residential skilled nursing. Expenses submitted by an in-network provider will continue to be covered, however, there will be no benefits payable for any charges submitted by

an out-of-network provider, which are related to an in-network residential treatment.

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:

- In-patient charges from an approved Hospice;
- 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.

## **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.

The Plan does not provide coverage for diabetic shoes.

## 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*

# Ineligible Medical Expenses

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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);
- Any services provided by an out-of-network residential treatment facility. This exclusion would include, but not limited to, services for inpatient or residential skilled nursing, alcohol and/or drug dependence rehabilitation. Expenses submitted by an in-network provider will continue to be covered. However, there will be no benefits payable for any charges submitted by an out-of-network provider, which are related to an in-network residential treatment.
- 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.

# Prescription Drug Benefit

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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 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;
- Levonorgestrel (Norplant);
- Mineral and nutrient supplements;
- Non-legend drugs other than insulin;
- Pigmenting and depigmenting agents; 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.**

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## **Notice to Medicare Eligible Participants**

The Plan provides normal Prescription Drug Benefits to Medicare eligible retirees and spouses. You do not need to purchase a Medicare Part D prescription drug benefit policy. In fact, if you do purchase a separate Part D policy, you will not be permitted to continue coverage through this Plan.

The coverage provided by this Plan is better than the basic Part D coverage. As such, should you ever decide to terminate your participation in the Plan, you will be provided a Certificate of Creditable Coverage. This Certificate will protect you from having to pay the surcharge for late enrollment in any Part D coverage you elect to purchase.

# Medicare Supplemental Plan Coverage

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The Plan offers a Medicare Supplemental coverage for Medicare eligible participants and requires you to have enrolled for both Medicare Part A and Part B benefits. The Plan will pay 80% of eligible Medicare deductibles and co-payments after you have met your calendar year deductible.

Medicare consists of two types of coverage:

- **Medicare Part A**  
Hospital insurance for hospital in-patient stays, skilled nursing facilities, home health and hospice care
- **Medicare Part B**  
Medical insurance for doctors, outpatient hospital care and other medical services

**Medicare Part A** benefits are automatically provided to you when you reach age sixty-five (65) and for disabled participants under age sixty-five (65) if:

- You are already receiving retirement benefits from Social Security
- You are eligible to receive Social Security benefits but have not yet filed for them
- You or your spouse had Medicare covered employment

**Medicare Part B** benefits must be elected and require you to pay a monthly premium. Anyone entitled to Medicare Part A benefits can enroll for Medicare Part B coverage.

When you become eligible for the Medicare Supplemental Plan, you will continue to be eligible for **Prescription Drug benefit** and **Dental/Vision Care benefit**, with the same coverage that you previously had in the Plan.

The Medicare Supplemental Plan also provides coverage for Hepatitis and Shingles Vaccinations, which are presently not covered by Medicare. The Plan will allow a maximum of \$300 paid at 80%, which is the same percentage used by the Plan in the processing of Medicare deductibles and co-payments.

Most providers will file a request for reimbursement for a Medicare covered service electronically. If the electronic filing procedure, commonly referred to as Medicare Crossover, is used, the Fund will process the necessary coordination and issue payment for eligible expenses. Should your provider not use the electronic filing procedure, the following process applies:

- Generally, your medical provider will submit their claim directly to Medicare for processing and you should receive a Medicare Explanation of Benefits (EOB). Your provider then will submit a copy of the original itemized bill sent to Medicare, along with a copy of the Medicare EOB to the Plan for processing;
- If your medical provider does not bill the Plan, you will need to submit a copy of the original itemized bill sent to Medicare, and attach a copy of the Medicare Explanation of Benefits. Please be sure to keep a copy of the information before submitting it to the Plan.

The Fund will process your claim within 30 days unless special circumstances require additional processing time. If additional time is needed to process your claim, the Plan may request additional information from you or the provider. You and/or your provider will have at least 45 days to submit additional information.

When certain expenses are not eligible under the Medicare Supplemental Plan, you will be notified that the claim is denied with an explanation of the reasons for the denial. You will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of any appeals rights that you may have available.

# Claims Procedures

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## Your Social Security Number

Your hours and contributions are processed by computer and you are classified by your Social Security Number. It is very important your Social Security Number is correctly reported to your employer and shown on the Employer Reporting forms. We will assign you a unique ID number which will be used on all statements and Explanation of Benefits sent to you from the Plan.

## Change of Address

If you change your address, you must notify the Trust Office. If you fail to do so, your Self-Contributions Notice may be delayed or lost and you may lose your eligibility. You also may not receive your quarterly statements and Explanations of Benefits.

## 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**

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 a 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.

## **Release of Information**

If you file a claim for benefits, you are required to authorize any physician, hospital, employer, government agency or any other person, corporation or organization having information which may be required for a proper determination of the claim to release such information to the Trustees.

## **Fraudulent Claims**

The filing of false claims will be deemed as fraud and the Trustees will pursue to the fullest extent of the law. Additionally, if payments are made under this Plan based upon fraudulent misrepresentations, the Plan may refuse to honor future claims until the amount paid due to fraudulent misrepresentations has been recouped as an offset against such claims.

## **Right of Recovery**

The Plan reserves the right to recover any monies paid in error to or on behalf of an individual, or to providers of health care. To the extent that payments are made by the Plan which are either in excess of the maximum amount necessary to satisfy the obligations of the Plan or are subsequently determined to have been incorrectly made, the Plan shall have the right to recover such excess or incorrect payments from any person or other entity to whom or for who such payments were made (including the individual), any insurance companies, or any other person or entity for whom repayment is appropriate as the Plan shall determine. Any individual may be required by the Plan to furnish information, to execute and deliver such documents, and otherwise to cooperate in whatever manner may reasonably be required to secure the Plan's rights to recover such payments.

## **Case Management**

The Plan reserves the right to contract with any appropriate firm for case management review services. Individuals are required to cooperate with the firm providing the case management review with regard to providing the authorization to receive medical records and other reports as requested. Failure to cooperate with the case management review firm may result in the Plan's denial of normal benefits.

## **Non-Discrimination**

Any provision of the Plan notwithstanding, the Plan shall at all times be interpreted, applied and administered so as to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Plan will not discriminate with respect to rules for eligibility or benefits based upon a health factor including:

- Health status;
- Medical condition;
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability; or
- Disability.

## **Procedure to Appoint an Authorized Representative**

Federal regulations allow a health plan to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a participant. The Plan will require a participant to complete a form that includes details about the covered participant, the designated authorized representative and the scope of the appointment. In addition, because in virtually all cases an authorized representative would need access to the participant's protected health information to effectively act on their behalf, a form allowing for disclosure of the protected health information must also be completed.

Effective March 1, 2010, any participant who would like an individual to act on his behalf with respect to the Plan must complete an Appointment of Authorized Representative Form. In addition, an Authorization Form for PHI Disclosure must be completed if the appointed authorized representative will be allowed access to the individual's protected health information (PHI).

## **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.

## **Right to Modify**

Any provision in this document notwithstanding, due to the exigencies inherent in any Health & Welfare Fund and the duty of the Trustees to provide benefits for all of the participants in amounts and kinds which may vary from time to time, no participant shall be deemed to have any vested interest in any benefit provided by the Fund and the Trustees expressly reserve the right to modify, add to, subtract from, or eliminate any benefit to any participant or group or class of participants as may be required under the circumstances.

# **Subrogation, Reimbursement and Accountable Person Responsibility**

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Subrogation and reimbursement allows the Fund the ability to recoup the value of any benefits (medical, disability, Rx, etc.) paid on behalf of a Participant/Dependent (“Claimant”) covered by this Fund who is injured or suffers an illness through the actions or omissions of a person or entity accountable for the injury or illness (hereinafter called “Accountable Person”). The subrogation and reimbursement process helps the overall financial stability of the Fund by ensuring the Fund is not the only entity paying for illness and injuries caused by Accountable Persons.

## **Right to Subrogate**

The Fund is subrogated to any and all rights of recovery and causes of action that the claimant may have against any Accountable Person, whether by suit, settlement, or otherwise, that may be liable for a Claimant’s injury or illness for which the Fund as paid or is obligated to pay benefits on the Claimant’s behalf.

Payment of benefits is conditional upon the Claimant’s written agreement to fully cooperate and reimburse the Fund for any benefits paid should the Claimant recover monies or damages, or be compensated for the illness or injury from the Accountable Person or any other source. The Claimant must sign forms assigning subrogation and reimbursement rights to the Fund. The Claims Administrator may withhold payment of any benefits due under the Fund until it receives the signed forms. Payment of Fund benefits before the signed forms are received does not modify or invalidate the Fund’s subrogation and reimbursement rights.

## **Rights to Reimbursement with Source of Funds Specifically Identified**

In situations where an Accountable Person is liable, the Claimant must reimburse the Fund the full value of the claims paid in connection with the illness or injury, but only to the extent he or she recovers settlement, judgment or insurance proceeds (from any source) connected with the illness or injury. A source includes, but is not limited to, an Accountable Person and/or an Accountable Person’s insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, an employer under the provisions of a workers’

compensation law, an individual policy of insurance maintained by a Claimant, and organization, corporation, or government agency.

The Fund's subrogation and reimbursement rights shall apply on a priority first-dollar basis to any recovery whether by suit, settlement or otherwise even through the Claimant may not have been fully compensated or "made whole" for all physical, psychological and/or financial damages. This provision rejects any "make whole" doctrine which would require a Claimant to be "made whole" before the Fund is entitled to assert its subrogation rights. Even though the subrogation rights of the Fund are specifically unequivocally due from the first dollar received by the Claimant or beneficiary, the Fund reserves the right to exercise judgment as to the facts of each case. In determining each individual case, even though the Fund has the right to recover from the first dollar received, the Trustees may consider and allow for the cost of collection from the Accountable Person, including reasonable attorney's fees incurred by the Claimant, in the sole discretion of the Trustees.

The Fund's rights also apply to any recovery made by a Claimant regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses.

## **Equitable Lien by Agreement**

Once the Fund makes or is obligated to make payments on behalf of a Claimant, the Fund is granted, and the Claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement, or judgment received by the Claimant or beneficiary from any source to the extent of payments made or to be made by the Fund on the Claimant's behalf.

## **Claimant Must Set Aside Funds**

The Claimant shall hold in trust for the Fund's benefit that portion of the total recovery from any source that is due for payments made or to be made. The Claimant shall reimburse the Fund immediately upon recovery.

## **Claimant's Duty to Reimburse**

The Claimant shall immediately notify the Fund if he or she is involved in or suffers an accident or injury for which an Accountable Person may be liable. The Claimant shall again notify the Fund if he or she pursues a claim to recover damages or other relief relating to an injury or illness for which the Fund may make payments on the Claimant's behalf. The

Claimant shall do nothing to impair, release, discharge or prejudice the Fund's rights to subrogation and/or reimbursement.

## **Reduction of Future Benefits**

The Claimant has the responsibility to seek damages for future accident-related benefit expenses. The Fund has the discretion to take into consideration future accident-related medical expenses in negotiating a settlement. The Fund may settle all accident-related claims (past, present and future) in full (meaning that upon settlement, the Fund shall not be responsible for any further accident-related benefit expenses). The Fund reserves the right to deny future accident-related benefit expenses. The Fund reserves the right to deny future accident-related care with the understanding that the Claimant shall be responsible for any future accident-related claims, as those benefits should be paid directly from the Claimant's settlement proceeds.

## **Disavowal of "Common Fund" Doctrine**

The Claimant shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying injury, sickness, accident or condition, and the Fund's recovery shall not be reduced by such legal fees or expenses.

The Fund further asserts that the "Common Fund" doctrine does not apply to any proceeds recovered by an attorney the Claimant or the Claimant's dependents may hire regardless of whether funds recovered are used to repay the benefits paid by the Fund.

The Fund specifically disavows any claims that a Claimant (a Participant and/or a Dependent) may make under any federal or state common law defense including, but not limited to, the make-whole doctrine and/or the Common Fund doctrine.

## **Cooperation**

The Claimant and legal representatives must do whatever is necessary to enable the Fund Administrator to exercise the Fund's rights and must do nothing to prejudice the Fund's rights. The Fund Administrator may require the Claimant to complete and/or execute certain documentation to assist the Fund in the enforcement of its subrogation rights including, but not limited to, a subrogation and reimbursement questionnaire and a repayment agreement.

The Claimant shall assist and cooperate with representatives the Fund designates. The Claimant shall do everything necessary to enable the Fund to enforce its subrogation and reimbursement rights. The claimant shall immediately notify the Fund upon receiving a judgement, settlement offer or compromise offer and shall not settle or compromise any claims without the Fund's consent.

In the event a Claimant fails to reimburse the Fund the full value of its subrogated interest or otherwise fails to cooperate, the Fund shall be entitled to suspend all benefit payments due to a Claimant and deduct the amount of the subrogated interest from future benefit payments or to apply employer contributions made to the Claimant's behalf against the amount owed to the Fund.

## Benefit Appeal Procedures

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### 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

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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**

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.

## **Dismemberment 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 you wish as your beneficiary. You may change your beneficiary at any time and 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.

All beneficiary designations must be in writing on the forms provided by the Trustees. If there is no valid designation on file with the Trustees, the beneficiary shall become one of the following in order of priority:

- surviving spouse,
- participant's estate

## **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

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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 will become Covered Individuals on the date we receive an updated Enrollment form and 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

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## How We Protect Your Privacy

We are required by law to protect the privacy of your protected health information and to provide you with this notice of our privacy practices. We will not disclose confidential information without your authorization unless it is necessary to provide your health benefits and administer the Plan, or as otherwise required or permitted by law. When we need to disclose individually identifiable information, we will follow the policies described in this Notice to protect your confidentiality.

We maintain confidential information and have procedures for accessing and storing confidential records. We restrict internal access to your confidential information to employees who need that information to provide your benefits. We train those individuals on policies and procedures designed to protect your privacy. Our Privacy Officer monitors how we follow those policies and procedures and educates our organization on this important topic.

## How We May Use and Disclose Your Protected Health Information

We will not use your confidential information or disclose it to others without your written authorization, except for the following purposes. When required by law, we will restrict disclosures to the Limited Data Set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

**Treatment.** We may disclose your protected health information to your health care provider for its provision, coordination or management of your health care and related services. For example, we may disclose your protected health information to a health care provider when the provider needs that information to provide treatment to you. We may also 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.

**Payment.** We may use or disclose your protected health information to provide payment for the treatment you receive under the Plan. For example, we may use and disclose your protected health information to pay and manage your claims, coordinate your benefits and review health care services provided to you. We may use and disclose your protected

health information to determine your eligibility or coverage for health benefits and evaluate medical necessity or appropriateness of care or charges. In addition, we may use and disclose your protected health information as necessary to preauthorize services to you and review the services provided to you. We may also use and disclose your protected health information to obtain payment under a contract for reinsurance, including stop-loss insurance. We may use and disclose your protected health information to adjudicate your claims. Also, we may disclose your protected health information to other health care providers or entities who need your protected health information to obtain or provide payment for your treatment.

**Health Care Operations.** We may use or disclose your protected health information for our health care operations. We may use or disclose your protected health information to conduct audits, for purposes of underwriting and rate-making, as well as for purposes of risk management. We may use or disclose your protected health information to provide you with customer service activities or develop programs. We may also provide your protected health information to our attorneys, accountants and other consultants who assist us in performing our functions. We may disclose your protected health information to other health care providers or entities for certain health care operations activities, such as quality assessment and improvement activities, case management and care coordination, or as needed to obtain or maintain accreditation or licenses to provide services. We will only disclose your protected health information to these entities if they have or have had a relationship with you and your protected health information pertains to that relationship, such as with other health plans or insurance carriers in order to coordinate benefits, if you or your family members have coverage through another health plan.

**Disclosures to the Plan Sponsor.** The Board Trustees of the IUOE Local 132 Health & Welfare Plan are the Plan sponsor. We may disclose your protected health information to the Plan sponsor. The Plan sponsor is not permitted to use protected health information for any purpose other than the administration of the Plan. The Plan sponsor must certify, among other things, that it will only use and disclose your protected health information as permitted by the Plan, it will restrict access to your protected health information to those individuals whose job it is to administer the Plan and it will not use protected health information for any employment-related actions or decisions. The Plan may also disclose enrollment information to the Plan sponsor. The Plan may also disclose summary health information to the Plan sponsor for purposes of obtaining bids for health insurance or lending or modifying the Plan.

**Disclosures to Business Associates.** We contract with individuals and entities (business associates) to perform various functions on our behalf

or provide certain types of services. To perform these functions or provide these services, our business associates will receive, create, maintain, use or disclose protected health information. We require the business associates to agree in writing to contract terms to safeguard your information, consistent with federal law. For example, we may disclose your protected health information to a business associate to administer claims or provide service support, utilization management, subrogation or pharmacy benefit management.

**Disclosures to Family Members or Others.** Unless you object, we may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. If you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, we will disclose protected health information (as we determine) in your best interest. After the emergency, we will give you the opportunity to object to future disclosures to family and friends.

**Other Uses and Disclosures.** The law allows us to disclose protected health information without your prior authorization in the following circumstances:

**Required by law.** We may use and disclose your protected health information to comply with the law.

**Public health activities.** We will disclose protected health information when we report to a public health authority for purposes such as public health surveillance, public health investigations or suspected child abuse.

**Reports about victims of abuse, neglect or domestic violence.** We will disclose your protected health information in these reports only if we are required or authorized by law to do so, or if you otherwise agree.

**To health oversight agencies.** We will provide protected health information as requested to government agencies that have the authority to audit or investigate our operations.

**Lawsuits and disputes.** If you are involved in a lawsuit or dispute, we may disclose your protected health information in response to a subpoena or other lawful request, but only if efforts have been made to tell you about the request or obtain a court order that protects the protected health information requested.

**Law enforcement.** We may release protected health information if asked to do so by a law enforcement official in the following circumstances: (a)

to respond to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) to assist the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) to investigate a death we believe may be due to criminal conduct; (e) to investigate criminal conduct; and (f) to report a crime, its location or victims or the identity, description or location of the person who committed the crime (in emergency circumstances).

**Coroners, medical examiners and funeral directors.** We may disclose protected health information to facilitate the duties of these individuals.

**Organ procurement.** We may disclose protected health information to facilitate organ donation and transplantation.

**Medical research.** We may disclose protected health information for medical research projects, subject to strict legal restrictions.

**Serious threat to health or safety.** We may disclose your protected health information to someone who can help prevent a serious threat to your health and safety or the health and safety of another person or the general public.

**Special government functions.** We may disclose protected health information to various departments of the government such as the U.S. military or U.S. Department of State.

**Workers' compensation or similar programs.** We may disclose your protected health information when necessary to comply with worker's compensation laws.

## **Uses and Disclosures With Your Written Authorization**

We will not use or disclose your confidential information for any purpose other than the purposes described in this Notice, without your written authorization. For example, we will not (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations), (2) sell your confidential information (unless under strict legal restrictions), or (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization. You may revoke an authorization that you previously have given by sending a written request to our Privacy Officer, but not with respect to any actions we already have taken.

## Your Individual Rights

You have the following rights:

Right to inspect and copy your protected health information. Except for limited circumstances, you may review and copy your protected health information. Your request must be addressed to the Privacy Officer. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual.

If you request copies of your protected health information, we may charge you a reasonable fee to cover the cost. Alternatively, we may provide you with a summary or explanation of your protected health information, upon your request if you agree to the rules and cost (if any) in advance.

Right to correct or update your protected health information. If you believe that the protected health information we have is incomplete or incorrect, you may ask us to amend it. Your request must be made in writing and must be addressed to the Privacy Officer. To process your request, you must use the form we provide and explain why you think the amendment is appropriate. We will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will make reasonable efforts to notify other parties of your amendment. If we agree to make the amendment, we will also ask you to identify others you would like us to notify.

We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person who created the information is no longer available to make the amendment;
- Is not part of the protected health information we keep about you;
- Is not part of the protected health information that you would be allowed to see or copy; or
- Is determined by us to be accurate and complete.

If we deny the requested amendment, we will notify you in writing on how to submit a statement of disagreement or complaint or request inclusion of your original amendment request in your protected health information.

Right to obtain a list of the disclosures. You have the right to get a list of protected health information disclosures, which is also referred to as an accounting. You must make a written request to the Privacy Officer to obtain this information.

The list will not include disclosures we have made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment and health care operations purposes (except as noted in the following paragraph). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list will not include other disclosures, including incidental disclosures, disclosures we have made for national security purposes, disclosures to law enforcement personnel or disclosures made before April 14, 2003. The list we provide will include disclosures made within the last six years (subject to the April 14, 2003 beginning date) unless you specify a shorter period.

You may also request and receive an accounting of disclosures of electronic health records made for payment, treatment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009, or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Right to choose how we communicate with you. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail). We must agree to your request if you state that disclosure of the information may put you in danger.

Right to request additional restrictions on health information. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction. However, we must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for these services in full, out of pocket.



## **Questions and Complaints**

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, put your complaint in writing and address it to the Privacy Officer listed below. The Plan will not retaliate against you for filing a complaint. You may also contact the Privacy Officer if you have questions or comments about our privacy practices.

## **Future Changes to Our Practices and This Notice**

We are required to follow the terms of the privacy notice currently in effect. However, we reserve the right to change our privacy practices and make any such change applicable to the protected health information we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. We will send or provide a copy of the revised Notice. You may also obtain a copy of any revised Notice by contacting the Privacy Officer.

## **Contact Information**

Jerry Moore, Privacy Officer  
IUOE Local 132 Health & Welfare Fund  
636 4th Avenue  
Huntington, WV 25701-0067

304-525-0482

# Rights and Protections Under ERISA

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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:

- 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.
- 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.
- 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.

## **Assistance with Questions**

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

If you have any questions about this statement or about your rights under ERISA, 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

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**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  
Huntington, WV 25701-0067

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

**Union Trustees**

Charles A. Parker, Secretary  
I.U.O.E. Local 132 AFL-CIO  
606 Tennessee Avenue  
Charleston, WV 25362-0770

William N. Huffman  
I.U.O.E. Local 132 AFL-CIO  
606 Tennessee Avenue  
Charleston, WV 25362-0770

**Employer Trustees**

D.W. Daniel, Jr., Chairman  
Wayne Concrete Company, Inc.  
P.O. Box 342  
Barboursville, WV 25504-0342

John M. Farley, II  
Triton Construction, Inc.  
PO Box 1360  
Saint Albans, WV 25177-1360

**Legal Counsel:** Lawrence B. Lowry  
I.U.O.E. Local 132  
636 Fourth Avenue, 2<sup>nd</sup> Floor  
Huntington, WV 25701-0067  
Phone: (304) 529-2434

Legal process may be served upon one or more Trustees.

# Better Understand Your Health

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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

### **Ophthalmologists (MD or DO)**

Ophthalmologists 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

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

Alzheimer's Association	1-800-272-3900 <a href="http://alz.org">alz.org</a>
American Academy of Dermatology	1-888-462-DERM <a href="http://aad.org">aad.org</a>
American Cancer Society	1-800-ACS-2345 <a href="http://cancer.org">cancer.org</a>
American Diabetes Association	1-800-232-3472 <a href="http://diabetes.org">diabetes.org</a>
American Dietetic Association	1-800-877-1600 <a href="http://eatright.org">eatright.org</a>
American Heart Association	1-800-242-9236 <a href="http://heart.org">heart.org</a>
American Kidney Fund	1-212-668-1000 <a href="http://kidneyfund.org">kidneyfund.org</a>
American Liver Foundation	1-800-223-0179 <a href="http://liverfoundation.org">liverfoundation.org</a>
American Lung Foundation	1-800-LUNG-USA <a href="http://lungusa.org">lungusa.org</a>
American Thyroid Association	1-800-THYROID <a href="http://thyroid.org">thyroid.org</a>
Arthritis Foundation	1-800-283-7800 <a href="http://arthritis.org">arthritis.org</a>
Asthma & Allergy Foundation of America	1-800-7-ASTHMA <a href="http://aafa.org">aafa.org</a>
Brain Injury Association	1-800-444-6443 <a href="http://biausa.org">biausa.org</a>



Centers of Disease Control and Prevention	1-800-332-4636 <a href="http://cdc.gov">cdc.gov</a>
Glaucoma Research Foundation	1-800-826-6693 <a href="http://glaucoma.org">glaucoma.org</a>
International Hearing Society	1-734-522-7200 <a href="http://ihinfo.org">ihinfo.org</a>
Lupus Foundation of America	1-888-38LUPUS <a href="http://lupus.org">lupus.org</a>
Medic Alert Foundation	1-800-432-5378 <a href="http://medicalert.org">medicalert.org</a>
Medicare Hotline	1-800-MEDICARE <a href="http://medicare.gov">medicare.gov</a>
Muscular Dystrophy Association	1-800-572-1717 <a href="http://mda.org">mda.org</a>
National Cancer Institute	1-800-422-6237 <a href="http://cancer.gov">cancer.gov</a>
National Council on Aging	1-800-424-9046 <a href="http://ncoa.org">ncoa.org</a>
National Hospice Organization	1-800-658-8898 <a href="http://nhpco.org">nhpco.org</a>
National Stroke Association	1-800-787-6537 <a href="http://stroke.org">stroke.org</a>



# Important Phone Numbers

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## IUOE Local 132

Trust Office	(304) 525-0482	1-800-642-3525
Charleston Union Hall	(304) 343-7731	1-888-440-9899
Beckley Branch Office	(304) 253-6898	
Clarksburg Branch Office	(304) 623-0791	
Glen Dale Branch Office	(304) 810-4183	
Petersburg Branch Office	(304) 257-0723	
Apprenticeship School	(304) 273-4852	1-800-376-4852

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  
with 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.**