



Your

Active

Health

Benefits

Summary

Plan

Description

2012

Contact

International Union of Operating Engineers
Local No. 478 Health Benefits Fund
1965 Dixwell Avenue
Hamden, Connecticut 06514-2400

Phone **1-866-288-9261 (Toll Free) or**
203-288-9261
Fax: 203-281-3894

Health Benefits Fund **Board of Trustees**

Union Trustees **Christopher Cozzi**
Craig Metz
Philip Rapuano

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John Olender, Sr.
Thomas J. Oneglia

Plan Administrator **Daniel E. Krause**

Legal Counsel **Norman Zolot, Esq.**
Reid & Riege, P.C.

Fund Consultants **The Segal Company**

Fund Auditors **Schultheis & Panettieri, LLP**

This Summary Plan Description has been prepared for Active Members of the International Union of Operating Engineers Local No. 478 Health Benefits Plan. The official Plan rules and regulations are in the legal Plan Document that establishes the Plan. If there is a discrepancy between this booklet and the Plan Document, the Plan Document will govern. The Trustees reserve the right to interpret, amend, or terminate the Plan at any time.

Welcome

International Union of Operating Engineers
Local No. 478 Health Benefits Fund
1965 Dixwell Avenue
Hamden, Connecticut 06514-2400
Phone: 203-288-9261 or 1-866-288-9261 (toll free)

FAST FACTS **About Your Health Plan**

The Board of Trustees of the International Union of Operating Engineers Local No. 478 Health Benefits Fund (Fund) is pleased to provide you with this updated Summary Plan Description (SPD), which contains current health and welfare benefits information regarding the International Union of Operating Engineers Local No. 478 Health Benefits Plan (Plan). This SPD replaces and supersedes any previous summary materials of the Plan regarding Active Health Benefits. In general, the benefits described in this booklet are effective January 1, 2012. *While every attempt has been made to ensure the accuracy of this booklet, if summaries of particular Plan benefits, features, practices or enrollment procedures are in conflict with the formal legal Plan document, the formal Plan document and approved procedures will prevail.*

As a member of the International Union of Operating Engineers Local No. 478 you're eligible for:

- Comprehensive medical coverage with an emphasis on wellness and preventive care;
- Top-notch dental, vision and prescription drug coverage;
- Access to great resources and help with mental health and/or substance abuse through the Engineers Family Assistance Program;
- Protection for you and your family with life insurance and accidental death and dismemberment insurance.



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It is the Trustees' goal to maintain a financially stable Fund while providing adequate health care coverage to our covered members and their families. This is becoming more challenging with additional mandates required by federal law, along with consistently increasing health care costs. You can do your part in helping the Fund manage health care costs by:

- **Visiting PPO providers** – PPO providers, including hospitals, physicians and other health care providers charge negotiated, reduced rates. Also, the Plan pays a higher percentage when you use a PPO provider, which means you pay less.
- **Requesting generic medications** – Often medications come in two forms: generic and brand name. Generic medications have to meet the same quality standards for pureness and effectiveness, but can cost much less than their brand name equivalent. Check with your doctor to see if a generic medication is appropriate for you. (Please see page 60) which refers to the CVS/Caremark Generic Step Therapy Program.)
- **Examining emergency treatment alternatives** – In the event of an emergency, the most important consideration is to seek medical care, especially in a life-threatening situation. However, in some cases, you can obtain the same level of care at a physician's office or an urgent care facility as in an emergency room. Keep your physician's telephone number easily accessible so you'll be prepared in case of an emergency.
- **Watching for fraud!** Always keep your Social Security Numbers and Fund identification numbers private. Closely examine any explanation of benefits (EOB) statement you receive from the Fund Office to verify that the service that was billed was the service you (or a family member) received. If there is a question, or you see a discrepancy, please contact the Fund Office.

**If you have questions about how the Plan works,
please call or write the Fund Office at:**

**International Union of Operating Engineers Local No. 478
Health Benefits Plan
1965 Dixwell Avenue
Hamden, CT 06514-2400**

**Phone:
(203) 288-9261
(866) 288-9261 (toll free)**

We've organized the information in this booklet in an easy-to-understand format and added the following sections:

- Contact Information – This tells you whom to call when you need certain information.
- Life Events – Details how your benefits are affected by the different events that can occur in your life.
- How to File a Claim – Gives you a step-by-step process for filing claims, including what you need to do if a claim is denied.
- Definitions – Defines important terms used throughout this SPD.

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The Plan provides Medical, Hospital, Dental, Vision, Weekly Disability, Death and Accidental Death and Dismemberment benefits. In addition, the Plan offers the Engineers Family Assistance Program or EFAP, a professional consultation and referral program managed by MHN, Inc. that assists with the treatment for personal and family problems, mental/nervous disorders, and alcohol and substance abuse.

While we were in the process of preparing this SPD, one of the most sweeping federal health care laws in United States history was passed, and it is commonly known as the Patient Protection and Affordable Care Act or the "Affordable Care Act." Under the Affordable Care Act, we are required to provide you with the following disclosure notice:

The Fund's Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted (in March of 2010). Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential health benefits (which went into effect for this Plan on January 1, 2011).

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the Fund's Executive Director, Mr. Daniel E. Krause, at 866-288-9621, extension 229 (toll free). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.

We also want you to know that under the Affordable Care Act, our Plan participates in a federal program administered through the U.S. Department of Health & Human Services known as the "early retiree reinsurance program" (ERRP for short). Under this program, our Plan may be reimbursed for a portion of

the claims expense incurred with respect to our pre-Medicare retiree participants and their beneficiaries. We anticipate that any amounts received as reimbursement will be used to maintain the level of benefits and monthly premiums. In order for our Fund to accept this reimbursement, we are required to provide a notice. We previously did so, but we wanted to be sure everyone sees it by including it in this SPD:

NOTICE ABOUT ERRP: You are a participant, or are being offered the opportunity to enroll as a participant, in an employment-based health plan—namely, our Plan—that is certified for participation on the Early Retiree Reinsurance Program (ERRP). ERRP is a Federal program that was established under the Affordable Care Act. Under ERRP, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in such a plan. By law, the program expires on January 1, 2014.

Under ERRP, the Fund's Board of Trustees may choose to use any reimbursements it receives from this program to reduce or offset increases in Plan participants' monthly contribution payments, co-payments, deductibles, co-insurance, or other out-of-pocket costs, as applicable. If the Board of Trustees chooses to use the ERRP reimbursements in this way, you, as a Plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and the Board of Trustees chooses to use the reimbursements for this purpose. The Board of Trustees may also use the ERRP reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees, and their families.

As additional guidance and regulations are issued under the Affordable Care Act, we expect more Plan changes and notices will be required. At times you may feel overwhelmed by the amount of information we provide you, but our goal is to comply with this law and help you understand how it impacts the Plan and the benefits we provide to you and your family.

We urge you to read this information and, if you're married, share it with your Spouse. Also, please keep this SPD with your important papers so you can refer to it when needed.

Finally, be sure that you *always* keep the Fund Office informed of your current mailing address and telephone number. Remember that all Fund notices and mailings are geared toward the latest address we have on file for you.

Sincerely,

Board of Trustees

Contact Information

If You Need General Information About ...	Contact ...
<ul style="list-style-type: none"> - Locating A PPO Provider (Active and Pre-Medicare participants only) 	Anthem BlueCross BlueShield Telephone: (800) 810-2583 Web site: www.anthem.com
<ul style="list-style-type: none"> - Pre-Certification of Inpatient Hospital or Rehabilitation Care 	Hines & Associates Telephone: (800) 323-3454 Web site: www.hinesassoc.com (Click on "online referrals" at the top of the screen)
<ul style="list-style-type: none"> - Medical Benefits And Claims - Vision Benefits (Indemnity) - Prescription Drug Claims - Weekly Disability Benefits - Death Benefits - Accidental Death And Dismemberment (AD&D) Benefits 	Fund Office International Union of Operating Engineers Local Union 478 Health Benefits Fund 1965 Dixwell Avenue Hamden, CT 06514 Telephone: (203) 288-9261 or (866) 288-9261 (toll free)
<ul style="list-style-type: none"> - Prescription Drug Program 	CVS/Caremark Telephone: (888) 790-8084 Specialty Pharmacy: (800) 237-2767 Web site: www.caremark.com
<ul style="list-style-type: none"> - Vision Benefits 	Davis Vision Network Telephone: (800) 999-5431 Web site: www.davisvision.com
<ul style="list-style-type: none"> - Behavior Health Benefits (EFAP Program) Participants must contact MHN to pre-certify any inpatient care 	MHN MHN Claims PO Box 14628 Lexington, KY 40512 Telephone: (800) 624-6864
<ul style="list-style-type: none"> - Dental Benefits 	Delta Dental of New Jersey Telephone: (800) 452-9310 (to locate a network provider: 1-800-DELTAOK) Web site: www.deltadentalnj.com



Schedule of Benefits

On the pages that follow, we provide a short description of all of the various Plan benefits, a discussion of any limitations or special rules associated with that benefit, and the payment rules that apply if you utilize an “In-Network” or “Out-of-Network” provider.

FAST FACTS

- In basic terms, the “In-Network” rules apply when you use a provider within the Plan’s PPO (see page 41).
- Please remember that the specific rules of the Plan document will apply in all situations.
- Contact the Fund Office using the information on page 5 if you have specific questions.



Your Health Care Benefits as an Active Member

Plan Year	The Plan utilizes the calendar year (January 1st through December 31st) as its Plan Year.	
Annual Maximum Benefit (2011-2013 only)	<p>\$1.5 million per Plan Year per Eligible Individual for the 2011 and 2012 Plan Years, and increasing to \$2.0 million per Eligible Individual for the 2013 Plan Year. The Annual Maximum Benefit or “AMB” will be eliminated as of January 1, 2014.</p> <p>The AMB encompasses both in-network and out-of-network benefits. <i>For purposes of tracking the ABM for an Eligible Individual in the 2011-2013 Plan Years, the Plan will only analyze and count benefits which are “Essential Health Benefits” within the meaning of the Patient Protection and Affordable Care Act of 2010 (PPACA). The AMB also includes any benefits obtained under the Retiree Programs.</i></p>	
General Benefit Formula Used to calculate benefits, except where otherwise indicated	<i>In-Network</i>	<i>Out-of-Network</i>
	After you make the appropriate copayment, the Plan reimburses at 100%* **	After \$200 individual/\$400 family deductible, the Plan reimburses at 80% (except where noted otherwise)*
<p>* Benefits paid will be subject to all Plan terms, including reasonable and customary (R&C) rules. R&C rules are also referred to as the Plan’s Maximum Allowable Cost or “MAC.” See page 44 for more information.</p> <p>** Where multiple services are provided by the same provider on the same day, the highest single co-pay will apply.</p>		

What is “MAC”?

Benefits paid will be subject to all Plan terms, including reasonable and customary (R&C) rules. R&C rules are also referred to as the Plan’s Maximum Allowable Cost or “MAC.” See page 44 for more information.

Section I. Preventive Care

Benefit	In-Network	Out-of-Network
<p>Physical Exam Benefit (Routine)</p>	<p><i>Limit of 2 per Plan Year—Encompassing both in- and out-of-network providers. Eligible Member and Spouse only—includes OB/GYN visit for eligible female member or Spouse. Lab work associated with Physical Exam paid under X-ray/lab benefit.</i></p>	<p>80% after deductible, subject to MAC. Lab work and covered immunizations are paid under X-ray/lab and immunizations benefit.</p>
<p>Well Child Benefit</p>	<p>Eligible child(ren) from birth generally to month which includes such child's 26th birthday (coverage can be extended in limited situations as described in this Booklet). Associated tests covered under X-ray/lab benefit and include tine, urinalysis, CBC or hemoglobin or hematocrit. Ages 13 through end of coverage: same tests, plus same labs as a covered adult (pap, cholesterol, thyroid screen).</p> <p>For both in- and out-of-network, the following schedule applies:</p> <p>From birth to day before 1st birthday—6 total visits allowed From age 1 to day before 5th birthday—6 total visits allowed From age 5 to day before 12th birthday—7 total visits allowed From age 12 to day before 26th birthday—1 visit per year*</p> <p><i>* A year is measured from child's birthday to the day before his/her next birthday.</i></p>	<p>80% after deductible, subject to MAC. Lab work and covered immunizations are paid under X-ray/lab and immunizations benefit.</p>
<p>Routine Immunizations</p>	<p>Eligible Member, Spouse and any eligible children. Immunizations which are recommended by the Center for Disease Control (CDC) for an Eligible Individual are paid under this benefit. The Fund will consult the CDC's recommendations at the time the immunization was received by the Eligible Individual. Such recommendations are posted on the CDC's Web site, which is currently: http://www.cdc.gov/vaccines/recs/schedules/default.htm</p>	<p>80% after deductible, subject to MAC.</p>

Benefit	In-Network	Out-of-Network
Conditional Immunizations	Eligible Member, Spouse and any eligible children. Certain other immunizations for an Eligible Individual are paid under this benefit when recommended by a physician, including immunizations when an Eligible Individual is travelling to a foreign country where a specific disease(s) (e.g., Hep. A, Typhoid, Yellow Fever or Polio) presents a serious health threat, Zostavax/Shingles for older Eligible Individuals, and HPV/Gardasil for female Eligible Individuals who are older than age 19.	
	100% of covered expenses.	80% after deductible, subject to MAC.
Dietary Counseling Benefit	Eligible Member, Spouse and any eligible children. Limited to 3 visits per Plan Year; encompasses in- and out-of-network benefits.	
	\$25 copayment per visit, then the Plan pays 100% of covered expenses up to combined Plan Year maximum.	80% after deductible, subject to MAC and Plan Year maximum.
Routine Screening Mammography	Eligible Member and Spouse only. Mammography associated with a diagnosis is paid under the X-ray/lab benefit. From 35th birthday to day before 40th birthday—1 occurrence allowed Age 40 and older —1 occurrence every year* These limits encompass both in- and out-of-network benefits. <i>*A "year" is measured from an individual's birthday to the day before his or her next birthday.</i>	
	\$25 copayment per occurrence, then the Plan pays 100% of covered expenses.	80% (no deductible), subject to MAC.

Section II. General Medical Care

Physician's Office Visit	Covers physician, physician's assistant and other practitioners, including but not limited to audiologists, podiatrists, acupuncturists, also inpatient visits by the physician.	
	\$25 copayment per visit, then the Plan pays 100% of covered expenses.	80% after deductible, subject to MAC.

Benefit	In-Network	Out-of-Network
Chiropractic Benefit	Includes massage therapy when ordered by a physician. Limit of 24 visits per Plan Year; encompasses both in- and out-of-network benefits.	
	\$25 copayment per visit, then the Plan pays 100% of covered expenses.	80% after deductible, subject to MAC.
Naturopath/ Homeopathic	Limit of 12 visits per Plan Year; encompasses both in- and out-of-network benefits.	
	\$25 copayment per visit, then the Plan pays 100% of covered expenses.	80% after deductible, subject to MAC.
X-Ray/ Lab Benefits	Covers outpatient tests, both diagnosis-related, including Human Papilloma Virus (HPV), and those associated with a Physical Exam (eligible member/spouse), and well-child visits (eligible children generally to month which includes 26th birthday). Also covered under this benefit are pathology charges that are not included on an In-patient hospital bill. Covered tests associated with Well Child Benefit: (i) birth to age 12 – HPV, tine, urinalysis, CBC, hemoglobin or hematocrit, and (ii) ages 13 to end of coverage also includes pap, cholesterol and thyroid screen. Telephone pacemaker test also included, as is Lead Test (cpt code 83655) for eligible children.	
	100% of covered expenses.	80% (no deductible), subject to MAC.
Miscellaneous Outpatient Benefits	Includes Outpatient Radiation Therapy, Cardiac Rehab, Outpatient Dialysis, Home IV Therapy, and allergy injections (J codes). Note that any Skilled Nursing, Physical Therapy, Speech Therapy and Occupational Therapy visits not covered under the Home Health Care Benefits may be covered under this benefit.	
	\$25 copayment per visit, then the Plan pays 100% of covered expenses.	80% after deductible, subject to MAC.

Benefit	In-Network	Out-of-Network
<p>Home Health Care Benefits</p>	<p>Covers charges for services rendered in the home by the following health care providers:</p> <ul style="list-style-type: none"> – Nurses – Home Health Aides – Physical Therapists – Social Worker – Speech Therapists – Occupational Therapists <p>Combined limit for all of these types of providers is 60 visits per Plan Year. The limit on the number of visits includes both in- and out-of-network claims.</p>	
	<p>100% of covered expenses.</p>	<p>80% after deductible, subject to MAC.</p>
<p>Hospice Care Benefit</p>	<p>For terminally ill Eligible Individuals. Benefits apply equally whether inpatient or home hospice is utilized.</p>	
	<p>100% of covered expenses.</p>	<p>80% after deductible, subject to MAC.</p>
<p>Rehab (Non-Custodial) Benefit</p>	<p>Skilled Nursing Facility for non-custodial rehabilitation services—must provide bi-weekly progress report. Payable for up to 12 weeks per year. All rehabilitation stays must be pre-certified prior to admission through Hines & Associates. For pre-certification, call Hines & Associates at (800) 323-3454.</p>	
	<p>100% of covered expenses.</p>	<p>80% after deductible, subject to MAC.</p>
<p>Infertility Benefit</p>	<p>Lifetime maximum benefit of \$5,000 for medical expenses related to infertility treatment for Eligible Member and Spouse. Encompasses both in- and out-of-network benefits. Covers all medically necessary treatments/procedures. Lifetime maximum relates to combined expenses incurred by Eligible Member and Spouse, but is tracked as to the Member. There is no lifetime limit under the Prescription Drug Benefit for medically necessary infertility drugs.</p>	
	<p>Covered services paid at 100% up to infertility maximum.</p>	<p>Covered services paid at 80% after deductible, subject to MAC, up to infertility maximum.</p>

Section III. Hospital, Surgical, Anesthesia, Ambulance Services*

Benefit	In-Network	Out-of-Network
Hospital Benefit	Includes charges billed via UB-04, including inpatient dialysis, inpatient lab work, inpatient radiation therapy, ER charges where eligible patient is admitted and outpatient surgery facility charges. ALL INPATIENT STAYS MUST BE PRE-CERTIFIED PRIOR TO ADMISSION THROUGH HINES & ASSOCIATES. Call Hines & Associates at (800) 323-3454.	
	\$105 copayment per admission, then the Plan pays 100% of covered expenses.	80% after deductible, subject to MAC.
Emergency Room Benefit	Hospital ER or free-standing urgent care center.	
	\$55 copayment per visit, then the Plan pays 100% of covered expenses.	80% after deductible, subject to MAC.
Surgeon's Benefit Major	Major procedures are those for which the amount considered (i.e., the negotiated fee or MAC) is \$800 or more.	
	\$105 copayment per operative session, then the Plan pays 100% of covered expenses.	80% after deductible, subject to MAC.
Surgeon's Benefit Minor	Minor procedures are those for which the amount considered (i.e., the negotiated fee or MAC) is less than \$800.	
	\$25 copayment per operative session, then the Plan pays 100% of covered expenses.	80% after deductible, subject to MAC.
Assistant Surgeon Benefit	\$105 copayment per operative session, then the Plan pays 100% of covered expenses.	80% after deductible, subject to MAC.
Anesthesiologist Benefit (includes nurse anesthetist)	Surgical—\$105 copayment per operative session, then the Plan pays 100% of covered expenses.	80% (no deductible), subject to MAC.
	Pain Management—\$105 copayment per inpatient admission, then the Plan pays 100% of covered expenses.	80% (no deductible), subject to MAC.

* Care for accidental ingestion of a controlled substance, organ and tissue transplants and maternity and obstetrics are covered as any other illness.

Benefit	In-Network	Out-of-Network
Organ & Tissue Transplant	Includes coverage for procurement. Treated as any other illness, i.e., no special restrictions, benefits paid under applicable benefits types, e.g., anesthesia, hospital, etc.	
	100% of covered expenses after applicable copayments.	80% after deductible, subject to MAC.
Ambulance (Ground/Air)	Considers both ground and air ambulance for emergency/medically necessary transport to the nearest facility or between two facilities.	
	\$55 copayment, then the Plan pays 100% of covered expenses.	80% (no deductible), subject to MAC.

Section IV. Durable Medical Equipment/Supplies

Orthotics Benefit	X-rays paid under X-ray/lab benefit. Podiatrist Visit covered under Physician's Office Visit benefit. Charges for orthotic device covered here. Benefit for device limited to \$200 per Plan Year. \$600 lifetime maximum encompasses both in- and out-of-network benefits.	
	100% of covered charges, subject to device, orthotic benefit and lifetime maximum.	80% after deductible, subject to MAC, device, orthotic benefit and lifetime maximum.
Hearing Aid Benefit	Audiology test paid under X-ray/lab benefit. Limited to one set of hearing devices (right and left) every 36 months —covers all expenses relating to the device itself; visit charges for audiologist covered under Physician's Office Visit.	
	90% of covered expenses.	80% of covered expenses, after deductible, subject to MAC.
Miscellaneous Medical Equipment/Supplies	Covers various medically necessary equipment/supplies including: blood glucose monitor, wheel chairs, blood pressure monitor and other supplies and durable medical equipment.	
	90% of covered expenses.	80% of covered expenses, after deductible, subject to MAC.

Section V. Other Benefits

NOTE: No deductible applied to these benefits

<p>Dental Benefit – Administered by Delta Dental</p>	<ul style="list-style-type: none"> – Diagnostic and Preventive—80% of negotiated fee or MAC; allows 2 cleanings/ exams per Plan Year – Restorative, Crowns, Prosthodontics—60% of negotiated fee or MAC – Implants—40% of negotiated fee or MAC up to \$1,200 per person, per Plan Year – Dentures—1 set every 5 years – Crowns/Post & Core/Bridgework - once every 5 years. <p>COB Claims paid using primary formula (i.e., 80%/60%/40%).</p>
<p>Orthodontia Benefit– Administered by Delta Dental</p>	<p>Maximum Benefit is 100% of negotiated fee or MAC up to \$1,200 payable when bands are inserted. One benefit per person per lifetime.</p> <p>COB claims paid using primary formula, i.e., 100% up to \$1,200 lifetime maximum.</p>
<p>TMJ Benefit – Administered by Delta Dental</p>	<p>X-Rays paid under X-ray/lab benefit.</p> <p>40% of negotiated fee or MAC—Lifetime Maximum benefit of \$500.</p>
<p>Accidental Death and/or Dismemberment</p>	<p>Eligible Member only and not available through COBRA. Currently paid through Reliance Standard Ins. Co. This benefit is non-taxable.</p> <ul style="list-style-type: none"> – Accidental Death—\$25,000 payable upon death – Loss of 2 limbs, sight of both eyes, or loss of 1 limb and sight of 1 eye—\$25,000 – Loss of 1 limb or sight of 1 eye—\$12,500 – Loss of at least 3 fingers or toes—\$6,250. <p>Submission of appropriate documentation is required.</p>

<p>Death Benefit</p>	<p>Eligible Member only and not available through COBRA. Currently paid through Reliance Standard Ins. Co. This benefit is non-taxable.</p> <p>\$25,000 payable upon death of Eligible Active Member and submission of appropriate documentation to Fund.</p> <p>NOTE: If eligibility as an Active Member is lost, Reliance Standard Ins. Co. offers a “conversion right” to an individual life insurance policy. Former Active Member must notify Reliance in writing within 31 days of loss of eligibility and pay applicable individual premium to Reliance on a timely basis. More information is on page 73.</p>					
<p>Weekly Disability</p>	<p>Payable only while an Eligible Active Member and not available through COBRA. In general, weekly disability benefits begin immediately in the event of an injury and after 8 days in the event of an illness. This is a taxable benefit.</p> <p>\$400 per week for up to 26 weeks per disability, subject to applicable Plan rules.</p>					
<p>Vision Benefit</p>	<p>Member, Spouse and eligible children age 13 and older on first day of Plan Year are eligible for one vision benefit every other Plan Year. Eligible children under age 13 on first day of Plan Year are eligible for one vision benefit every Plan Year.</p> <p>Special Rules: When this Plan is secondary, we will consider the lower of the other plan’s allowed amount or our MAC amount. Maximum benefit payment amounts are those paid under the Indemnity Vision Plan. Coordination of benefits is only permitted with the Indemnity Vision Plan. Under either Plan, an Eligible Individual has 90 days from the date of the eye exam to purchase materials (lenses, frames, contacts, etc), provided a limited exception applies where there is eye surgery after the eye exam.</p> <table border="1" data-bbox="451 1457 1414 2032"> <thead> <tr> <th data-bbox="451 1457 924 1509">Davis Vision Plan</th> <th data-bbox="924 1457 1414 1509">Indemnity Vision Plan</th> </tr> </thead> <tbody> <tr> <td data-bbox="451 1509 924 2032"> <p>Eye Exam—100% of Cost</p> <p>Lenses and Frames—100% of cost of frames from Plan Collection; includes coverage of a pair of safety glasses for a Member only</p> <p>Contacts—100% of cost of lenses from Plan Collection, less \$25 copayment</p> <p>Other cost sharing rules apply for lens options, etc.</p> </td> <td data-bbox="924 1509 1414 2032"> <p>Plan pays the MAC for the following services and vision products: Eye Exams, Frames Only, Single Vision Lenses with Frames, Bi/Trifocal Lenses, Bi/Trifocal Lenses with Frames, Contact Lenses</p> </td> </tr> </tbody> </table>		Davis Vision Plan	Indemnity Vision Plan	<p>Eye Exam—100% of Cost</p> <p>Lenses and Frames—100% of cost of frames from Plan Collection; includes coverage of a pair of safety glasses for a Member only</p> <p>Contacts—100% of cost of lenses from Plan Collection, less \$25 copayment</p> <p>Other cost sharing rules apply for lens options, etc.</p>	<p>Plan pays the MAC for the following services and vision products: Eye Exams, Frames Only, Single Vision Lenses with Frames, Bi/Trifocal Lenses, Bi/Trifocal Lenses with Frames, Contact Lenses</p>
Davis Vision Plan	Indemnity Vision Plan					
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<p>Prescription Drug Benefit</p>	<p>Benefits provided exclusively via the CVS/Caremark Network, except where this Plan is secondary. (When this Plan is secondary, this Plan will pay (COB) 80% of non-covered portion of the charge.)</p> <p>The Fund has implemented the following CVS Caremark Drug programs: Mandatory Mail order with Maintenance Choice and the Generic Step Therapy Program.</p>	
<p>Behavioral Health Benefit</p>	<p>GENERAL: ALL INPATIENT care for Active Members and their Eligible Dependents must be precertified with the Plan’s gatekeeper, MHN, by calling them at 1-800-624-6864. Services must be rendered by an MHN network provider or they will be considered as out-of-network. Outpatient care does NOT require prior authorization but, out-of-pocket savings may be greater if an MHN provider is utilized. Telephonic visits or counseling sessions provided at no cost by MHN are not counted against the limits noted below. Eligible Individuals can receive the first 3 Employee Assistance Program (EAP) counseling sessions per incident, and per calendar year, at no cost.</p>	
	<p>Retail Pharmacy 30-Day Supply*</p> <p>Generic Copayment—lesser of drug cost or \$15</p> <p>Brand (Formulary) Copayment—lesser of drug cost or \$30</p> <p>Brand (Non-Formulary) Copayment—lesser of drug cost or \$45</p>	<p>Mail-Order 90-Day Supply*</p> <p>Generic Copayment—lesser of drug cost or \$25</p> <p>Brand (Formulary) Copayment—lesser of drug cost or \$55</p> <p>Brand (Non-Formulary) Copayment—lesser of drug cost or \$85</p>
	<p><i>*Other limits may apply</i></p>	
	<p>In-Network MHN</p> <p>\$25 copayment per out-patient visit (\$55 for ER care) then the Plan pays 100% of covered expenses.</p> <p>\$105 copayment per inpatient admission then the Plan pays 100% of covered expenses.</p>	<p>Out-of-Network</p> <p>Inpatient and outpatient benefits paid at 80% after deductible, subject to MAC.</p>
	<p>COB Rule—When this Plan is secondary, we will consider the other plan’s allowed amount only if that plan utilizes a precertification program such as our Plan. If the other plan does not utilize such a program, participants will be required to utilize our EFAP program through MHN as if we were the primary payer.</p>	

Changes, and anticipated changes for 2012 and beyond

1. The Board of Trustees recently voted to implement case management practices for catastrophic care and pre-certification in various situations, such as inpatient hospital admissions, inpatient rehabilitation, and skilled nursing facility care, including length of stay. So, before you or an eligible dependent is admitted to the hospital on an inpatient basis, you will need to contact the Fund's medical review company Hines & Associates.
2. The Board of Trustees has also voted to make various changes to the Fund's prescription drug program to ensure that generic drugs are utilized in appropriate situations and that the Fund's mail order program is normally utilized when obtaining maintenance prescription drugs.
3. Finally, as additional guidance regarding the new federal health care law (known as the "PPACA") is published, the Fund will be sure to comply with the various provisions of the PPACA that apply to the Fund. Remember that the Fund currently has "grandfathered" status, so not every single PPACA change will apply to the Fund.



Eligibility

As an employee, your eligibility for Health Benefits is determined by the hours actually paid on your behalf by your contributing employer(s). Hours are not credited on your behalf until the contributions are received by the Fund Office. You should call the Fund Office at 866-288-9261 (toll free), Ext. 631 if you are concerned that your employer might be delinquent. Generally speaking, once you have established a “bank of hours” and continue to work on a regular basis, you should have relatively few problems concerning your eligibility.

FAST FACTS

- You are eligible to participate in the Plan if your employer makes contributions to the Health Fund on your behalf and you meet certain hours requirements.
- Once you become eligible to participate, your eligible children and spouse are eligible for benefits under the Plan, too.
- If you don't work enough hours to qualify for benefits, you and/or your dependents may be able to purchase Continuation Coverage under the federal program known as COBRA.



Initial Eligibility

The Fund runs three (3) separate tests to determine if you are initially eligible for Health Benefits. As indicated above, all three (3) tests look at the hourly contributions actually received by the Fund Office on your behalf over the past number of months. Under the tests, you will become initially eligible for Health Benefits on the first day of the month that follows the month after the Fund receives:

- (1) at least 200 hours of contributions in the last three (3) or fewer calendar months, or
- (2) at least 400 hours of contributions in the last six (6) or fewer calendar months, or
- (3) at least 800 hours of contributions in the last twelve (12) or fewer calendar months.

In addition, you must be working in Covered Employment or for an eligible Contributing Employer, or you must be registered with the Union Hall as available for and actively seeking work in Covered Employment.

When Coverage Begins

Coverage begins the first day of the second calendar month following the month you satisfy one of the above tests.

EXAMPLE

Charles begins work on October 1, 2011 and the Fund Office receives the following contributions for his Covered Employment in October (125 hours) and November (125 hours). As he satisfies test (1) as of the end of November 2011 and his contributions are received, he will be eligible for coverage for the month of January 2012.

Active Members are eligible for:

- **Medical benefits;**
- **Prescription drug benefits;**
- **Dental benefits;**
- **Vision benefits;**
- **Weekly Disability benefits;**
- **Death benefits; and**
- **Accidental Death and Dismemberment (AD&D) benefits.**

Special Exception – Immediate Eligibility Rule

In certain situations where an employer initially signs a Collective Bargaining Agreement (so as to become a Contributing Employer for the first time), then employees of that Employer will be immediately eligible for Fund coverage, provided that:

- At the time the Collective Bargaining Agreement was signed the Employer offered health insurance coverage to its employees; and
- The Employer reports, and contributes on a timely basis to the Fund Office, all contributions that are due based on the work of its employees in Covered Employment.

After becoming “immediately” eligible under this special exception, any employee of the Employer must meet the requirements for continuing eligibility as described below.

Continuing Eligibility

For Active Members

Your eligibility will continue on a month-to-month basis as long as you are working for a Contributing Employer, continuous contributions are received on your behalf, and you meet one of the three eligibility tests described in the Initial Eligibility section. All three (3) tests are run monthly.

We note that the tests are not locked into the calendar quarter calculations utilized by many plans, instead they are administered for rolling monthly periods. The month immediately preceding the month for which eligibility is being determined (what we normally call the “skip month”) is ignored in order to allow for the time required to receive contributions remitted on your behalf.

On the next page is an example of how these rules operate, assuming that you are new to the Local as of 1/1/11 (note: “I” is ineligible, while “E” is eligible), and also note that the month worked by you can generate possible eligibility takes the skip month into account.

Month Worked by You	Hours Remitted to Fund	Possible Eligibility Month	Test #1	Test #2	Test #3	Comment(s) as to three tests
01/11	120	03/11	I	I	I	Tests look back for 200, 400, or 600 hours; I – 3/11
02/11	100	04/11	E	I	I	220 hrs in 3 or less mos; Test 1 met; E – 4/11
03/11	80	05/11	E	I	I	300 hrs in last 3 mos; Test 1 met; E – 5/11
04/11	160	06/11	E	E	I	340 hrs in last 3 mos; 460 hrs in < 6 mos; Tests 1 & 2 met; E – 6/11
05/11	200	07/11	E	E	I	440 hrs in last 3 mos, 660 hrs in < 6 mos; Tests 1 & 2 met; E – 7/11
06/11	200	08/11	E	E	E	560 hrs in last 3 mos; 860 hrs in last 6 mos; 860 hrs in < 12 mos; All Tests met; E – 8/11
07/11	200	09/11	E	E	E	600 hrs in last 3 mos; 940 hrs in last 6 mos; 1060 hrs in < 12 mos; All Tests met; E – 9/11
08/11	100	10/11	E	E	E	500 hrs in last 3 mos; 940 hrs in last 6 mos; 1160 hrs in < 12 mos; All Tests met; E – 10/11
09/11	100	11/11	E	E	E	400 hrs in last 3 mos; 960 hrs in last 6 mos; 1260 hrs in < 12 mos; All Tests met; E – 11/11
10/11	80	12/11	E	E	E	280 hrs in last 3 mos; 880 hrs in last 6 mos; 1340 hrs in < 12 mos; All Tests met; E – 12/11
11/11	0	01/12	I	E	E	180 hrs in last 3 mos; 680 hrs in last 6 mos; 1340 hrs in < 12 mos; Tests 2 & 3 met; E – 1/12
12/11	0	02/12	I	E	E	80 hrs in last 3 mos; 480 hrs in last 6 mos; 1340 hrs in last 12 mos; Tests 2 & 3 met; E – 2/12
01/12	0	03/12	I	I	E	0 hrs in last 3 mos; 280 hrs in last 6 mos; 1220 hrs in last 12 mos; Test 3 met; E – 3/12
02/12	0	04/12	I	I	E	0 hrs in last 3 mos; 180 hrs in last 6 mos; 1120 hrs in last 12 mos; Test 3 met; E – 4/12
03/12	0	05/12	I	I	E	0 hrs in last 3 mos; 80 hrs in last 6 mos; 1040 hrs in last 12 mos; Test 3 met; E – 5/12
04/12	0	06/12	I	I	E	0 hrs in last 3 mos; 0 hrs in last 6 mos; 880 hrs in last 12 mos; Test 3 met; E – 6/12
05/12	0	07/12	I	I	I	0 hrs in last 3 mos; 0 hrs in last 6 mos; 680 hrs in last 12 mos; No Test met; I – 7/12

In this example, once you fail to meet any one of the three eligibility tests, your coverage will end at the end of the applicable month (in this example, June 2012).

Even when you lose eligibility, you may be able to continue your coverage for you and any eligible dependents by making self-payments for COBRA continuation coverage. Please see page 31 for more details.

Reciprocity

If you work in Covered Employment with another I.U.O.E. Local Union covered under a reciprocal agreement, you may be able to maintain coverage under this Plan temporarily while working under the jurisdiction of another Local Union. These reciprocal agreements allow for the transfer of hours and associated contributions from one I.U.O.E. Health Fund to another I.U.O.E. Health Fund, and the purpose of

these agreements are to provide for continuity of coverage.

Please be aware that it is your responsibility to notify the Fund Office if you work in another jurisdiction, and to complete any required documents before you start such work so that your hours and contributions can be reciprocated to this Fund. Contact the Fund Office for more information.

The Fund's Alumni Program

The Fund has established an Alumni Program which allows individuals who meet the definition of Alumni (see page 101) to participate in the Fund. Additional rules apply to individuals employed by Limited Liability Companies or LLCs so that the Fund complies with complicated Internal Revenue Service rules. Assuming an individual meets all of the various requirements to become an Alumni, the current monthly

contribution required for participation in the Alumni Program is equal to the standard Collective Bargaining Agreement rate multiplied by 150 hours. Contributions made under the Alumni Program must be made on a timely basis, and various other rules apply.

Newly hired Alumni, or individuals who transition to Alumni status (by moving from employment covered by the Collective Bargaining Agreement to an individual who qualifies as an Alumni) will be allowed to participate in the Plan under the Alumni Program ***if the Alumni and his/her employer file the required documents with the Fund Office within thirty (30) days of the date of the Alumni's date of hire or change in status.*** If necessary documents are not received on a timely basis, those who would otherwise qualify as Alumni will not be covered under the Alumni Program.

While the Fund may open a “window” for participation in the Alumni Program, the bottom line is that if you are interested in the Alumni Program and think you could qualify, please contact the Fund Office immediately for more information!

Dependent Eligibility

While you are eligible, Eligible Dependents include your:

- Spouse;
- Your children from birth to the last day of the month which includes the particular child's 26th birthday, except that for the period from January 1, 2011 through December 31, 2013, if such a child is age 19 or older **and** is eligible to enroll in an employer-sponsored health plan (other than through this Plan or a plan of your Spouse), that child is not eligible;

Child means natural child, legally adopted child, foster child and stepchild. In some situations, it can also include a grandchild.

Children over age 26 may be eligible for coverage if they are mentally or physically disabled.

- Children who you or your covered Spouse are required to provide medical coverage for under a Qualified Medical Child Support Order (QMCSO), assuming they otherwise meet the Plan's rules for the coverage of children;
- Prior to January 1, 2011, the Plan provided coverage to an unmarried child over age 19 who was incapable of self-sustaining employment because of a physical or mental disability, provided:
 - The disability began before age 19; and
 - You maintained coverage under the Plan, and provided proof of incapability to the Fund Office no later than 30 days before the date the child reached age 19. If you did not notify the Fund Office of the child's incapacity within the 30-day limit, the child's coverage under the Plan would end under the Plan rules as in effect prior to January 1, 2011. We note that it is still possible to reinstate coverage for an incapacitated child who was disabled before age 19 **on a prospective basis only** by notifying the Fund Office of the child's continued incapacity. You would be required to provide proof of the child's incapacity to the Fund Office from time to time as required by the Trustees.

- On and after January 1, 2011, the Plan will provide coverage to a child over age 26 who is incapable of self-sustaining employment because of a physical or mental disability, provided:
 - The disability began before age 26; and
 - You maintain coverage under the Plan, and provide proof of incapability to the Fund Office no later than 30 days before the date the child reaches age 26. If you did not notify the Fund Office of the child's incapacity with the 30-day limit, the child's coverage under the Plan will terminate as of the last day of the month which includes the child's 26th birthday. It is possible to reinstate coverage for an incapacitated child who was disabled before age 26 **on a prospective basis only** by notifying the Fund Office of the child's continued incapacity. You will be required to provide proof of the child's incapacity to the Fund Office from time to time as required by the Trustees.

If you and your Spouse are both eligible for coverage under the Plan, your Spouse will be considered an Eligible Dependent. In such situations, the Plan may utilize its Coordination of Benefits provision (explained on page 87) to the extent necessary.

When Dependent Coverage Begins

Dependent coverage for a spouse or any child begins on the same date your eligibility begins, or if applicable, a later date such as the date you acquire a new eligible dependent or as specified in a Qualified Medical Child Support Order. You should always notify the Fund Office of the addition of a new dependent.

When Eligibility Ends

When your coverage ends, you and any of your eligible dependents will be provided with certification of your length of coverage under the Plan. This may help reduce or eliminate any pre-existing condition limitation under a new group medical plan.

For Active Members

When you or your eligible dependents' coverage ends, you or your dependent(s) may be eligible to continue coverage by making monthly COBRA (see page 31) payments. However, COBRA is not available in all situations, including if you lose coverage due to a Termination for Cause.

Coverage ends for you and all of your dependents on the earliest of the following:

- The last day of the month for which you satisfy one of the Plan's three eligibility tests (see page 19) for continued coverage (i.e., your coverage ends as of the first day of the month in which you do not satisfy any of the three tests);
- You become covered under one of the Fund's Retiree Programs (at which point coverage for you and any of your dependents will transition to the applicable Program);
- The last day of the month in which you engage in either work in Non-Covered Employment or conduct which constitutes a Termination for Cause (see page 107 and 108); or
- As of the point in time that you provide any false, misleading, mistaken or fraudulent representations to the Fund, or withhold information from the Fund, and the Plan pays benefits to an individual or entity (including an estate) that would not otherwise be eligible to receive such benefits; or

- The day the Plan is terminated.

If you are eligible for continued coverage based on the Family and Medical Leave Act (FMLA) or the Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA), you may continue coverage as required by FMLA and USERRA.

If you have an injury or illness that arises out of or in connection with work in Covered or Non-Covered Employment, no benefits are payable by the Fund. If you file a claim for workers' compensation, but the claim is contested by your employer, the Fund may pay benefits for the same injury or illness whether or not a lien is filed.

For Your Eligible Dependents

Your eligible dependent's eligibility will end on the earliest of:

- The date your eligibility under the Plan ends; or
- The date you become covered under one of the Fund's Retiree Programs (at which point coverage for you and any of your dependents will transition to the applicable Program); or
- The last day of the month in which your dependent engages in either work in Non-Covered Employment or conduct which constitutes a Termination for Cause (see page 107 and 108); or
- The date your dependent becomes a Member (at which point he or she will have coverage as a Member); or

- The last day of the month your dependent no longer meets the Plan's definition of a dependent (subject to the provisions of any applicable QMCSO for a child); or
- The date of your death, provided that coverage for your dependents will continue until the date your eligibility would have ended had you not died; or
- As of the point in time that your dependent provides any false, misleading, mistaken or fraudulent representations to the Fund, or withhold information from the Fund, and the Plan pays benefits to an individual or entity (including an estate) that would not otherwise be eligible to receive such benefits; or
- The day the Plan is terminated.

If your eligible dependent's coverage ends, he or she may be eligible for COBRA continuation coverage as described on page 31. As with Active Members, COBRA is not available in all situations for eligible dependents, including if an eligible dependent loses coverage due to a Termination for Cause.

Reinstatement of Eligibility

If your eligibility ends under the Plan, you can become eligible again by meeting the one of the three eligibility tests described on page 19.

Eligibility and Retirement from the I.U.O.E. Local No. 478 Pension Fund

Your retirement under the terms of the International Union of Operating Engineers Local No. 478 Pension Fund can impact your eligibility, and that of any eligible dependents, in this Fund.

As a general rule, even if you have eligibility under this Fund extending into the future, your eligibility will be terminated one month after the effective date from your retirement from the Pension Fund. The basic reason for this is that due to your retirement you are no longer “available for and actively seeking work in Covered Employment” as required by Plan rules. For example, if you were eligible for Fund coverage through October 31, 2011 and retired under the Pension Fund and began receiving pension benefits on June 1, 2011, your Fund eligibility would end on June 30, 2011. We note that a large number of individuals who retire from the Pension Fund are eligible to maintain health coverage under one of the Retiree Programs, provided they make appropriate and timely elections and pay the applicable Retiree Program co-payments on time. More information is available regarding the transition to Retiree benefits on our Web site – www.local478.org.

COBRA

Even if you or an eligible dependent loses Fund coverage, you or they may be able to elect COBRA coverage. In short, COBRA is a federal law which allows individuals to make self-payments to continue Fund coverage for a period of time after normal eligibility otherwise ends. Much more information on COBRA begins on page 31.



Life Events

Your benefits are designed to meet your needs at different stages of your life. This section describes how your Plan benefits are affected when different lifestyle changes occur after you become covered under the Plan.

FAST FACTS

- You should notify the Fund Office as soon as possible if you experience a life event that may affect your coverage.
- You and/or your dependents may qualify to continue coverage under COBRA in the event of a loss of eligibility, divorce, or your termination or reduction of your work hours.
- If you are covered by the Fund and out of work due to a non-work related disability, you may be eligible to receive Weekly Disability benefits.



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

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

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

- **In all situations, the child's birth certificate (long form) and a copy of your child's other medical insurance information, if he or she is covered under another plan.**
- **For foster children and/or adopted children, the legal documentation showing that the child has been placed with you, along with the effective date.**
- **For stepchildren, a copy of your marriage certificate. For grandchildren, a copy of the court order awarding you custody, along with the effective date.**

Getting Married

When you are covered by the Plan and get married, your Spouse is eligible for medical, prescription drug, dental, and vision coverage. However, you need to notify the Fund within thirty (30) days of the marriage. Once the timely notice is received and the Fund Office receives the required information (see note at left), coverage for your Spouse will be effective as of the date of your marriage. You should also consider whether you want to update your beneficiary information for your Death and AD&D benefits.

If your Spouse is covered under another group medical plan, you must report such other coverage to the Fund Office. The amount of benefits payable under this Plan will be coordinated with your Spouse's other coverage; benefits for your Spouse under this Plan will be paid after any benefits are payable from your Spouse's plan.

Adding a Child

When you properly add an eligible child to your coverage, whether at the time you become covered under the Plan or through birth, a foster child program, adoption or marriage (i.e., adding stepchildren), your child is eligible for medical, prescription drug, dental, and vision coverage. However, in situations involving birth, a foster child program, adoption or marriage, you need to notify the Fund within thirty (30) days of the addition of such child (see page 23 for more details). Once the timely notice is received and the Fund Office receives the required information (see note at left), coverage for your child will be effective as of the date: (i) of the child's birth, or (ii) the adoption or date the child is placed with you.

Stepchildren are also eligible for coverage on the date of your marriage. A grandchild may also be covered under the Plan, **provided** that you have legal custody of such grandchild.

In all situations, you must provide the required information (see note at right) and the child must meet the Plan's Dependent Eligibility rules (see page 22).

IMPORTANT NOTES

Under federal law, the two life events noted above trigger a "special enrollment right." Simply put, if you provide all required documentation to the Fund Office within thirty (30) days of the marriage to a Spouse or the addition of a child, coverage for your new dependent(s) will begin as of the date of the event. If the required documentation is not received within the 30-day period, your new dependents will still be added, but Fund coverage will not begin until the first of the month after all of the documentation is received.

There are additional special enrollment rights available to those participants and children who are eligible for assistance under Medicaid or CHIP (the Children's Health Insurance Program offered by a number of states, but not Connecticut at this time). In such instances, the Fund is required to permit you and your eligible dependents to enroll in the Fund – as long as you and your dependents are eligible, but not already enrolled. ***You must make a written request for Fund coverage within 60 days of being determined eligible for this assistance.*** If you or your dependents lose coverage under a Medicaid or CHIP plan and you and your dependents are otherwise eligible for Fund coverage, you also have a special enrollment opportunity if you make a written request to enroll in the Fund within 60 days of losing such Medicaid or CHIP coverage.

Contact the Fund Office if you have any questions about either of these special enrollment rights.

Getting Legally Separated or Divorced

If you and your Spouse get a legal separation or divorce, your former spouse will no longer be eligible for coverage as a dependent under the Plan. However, your former spouse may elect to continue coverage under COBRA for up to 36 months. You or your former spouse must notify the Fund Office within **60 days** of the divorce or legal separation date for your former spouse to obtain COBRA continuation coverage. At this time, you may also want to review your beneficiary designation(s) for any Death and AD&D benefits.

If you get legally separated or divorced, immediately provide the Fund Office with:

- **A copy of your separation or divorce decree.**
- **A copy of any QDRO.**
- **If you have children, a copy of any QMCSO.**

If your former Spouse wants to continue coverage, he or she must:

- **Contact the Fund Office; and**
- **Enroll for COBRA continuation coverage.**

This Plan recognizes Qualified Domestic Relations Orders (QDROs) and Qualified Medical Child Support Orders (QMCSOs). A QDRO is a court order or administrative order which assigns certain Plan benefits to an “alternate payee” (a spouse, former spouse or child), assuming you are otherwise eligible for such benefits. A Qualified Medical Child Support Order (QMCSO) is a court order or administrative order, which has the force of law pursuant to the state’s administrative procedure, relating to child support or that provides for a child’s continued coverage under the Plan while you are eligible. A copy of the Plan’s QDRO and/or QMCSO qualification procedures may be obtained, free of charge, by contacting the Fund Office.

Losing Your Eligibility

A detailed description of the requirements needed to continue eligibility is shown on page 20. If you are an Active Member and your eligibility ends, you can become eligible again by meeting the eligibility requirements as described on page 19. As a general rule, when your coverage ends, you will be eligible to continue coverage by making monthly self-payments for COBRA continuation coverage (see page 23).

If your child is no longer eligible for coverage under the Plan, he or she can elect to continue coverage under COBRA continuation coverage. Within 60 days of losing eligibility for coverage, he or she must:

- **Contact the Fund Office.**
- **Enroll for COBRA continuation coverage if he or she plans to continue coverage under the Plan.**

Child Losing Eligibility

In general, even if you have Fund coverage, your child is no longer eligible for Fund coverage as of the end of the month in which he or she attains age 26, provided that the Fund has an exclusion for the period 2011 through 2013 for children age 19 or older who have access to certain other employer-sponsored health coverage. You must notify the Fund Office within 60 days of the date that your child is no longer eligible for coverage. Your child may be able to elect to continue coverage by making COBRA self-payments for up to 36 months.

When You Are Out of Work Due to Disability

For those who engage in Covered Employment, if you are covered by the Fund and then out of work due to a non-work related disability, you may receive Weekly Disability benefits until you recover or receive the maximum number of weeks of benefits for one period of disability, whichever occurs first. In addition, the Fund will continue to run the eligibility tests (which start on page 19) to determine your continued eligibility under the Plan. ***Eligibility for Weekly Disability benefits will end when you lose your coverage as an Active Member, including due to your retirement. Weekly Disability benefits are paid once every other week.***

The Fund requires proof of disability that is satisfactory to the Trustees. The Fund also has the right to require you to submit to a medical examination.

If you become disabled due to an injury that is covered by the AD&D (Accidental Death & Dismemberment) benefit, you may also be eligible for an AD&D benefit.

If you are out of work due to a work-related disability, you may be eligible for workers' compensation benefits. Contact your local or state workers' compensation office. The Fund does not provide coverage for work-related disabilities, and Employer(s) and/or any workers' compensation carrier(s) do not make contributions to the Fund on your behalf.

In sum, always notify the Fund Office of any type of injury! In addition to possible benefits under this Fund, the I.U.O.E. Local No. 478 Pension Fund provides credit for certain periods of disability. See pages 71-72 for more detail regarding Weekly Disability Benefits.

If you are out of work due to a non-work related disability:

- **Notify your employer and the Fund Office.**
- **Provide the Fund Office with proof of your disability.**
- **Apply for Weekly Disability Benefits.**

If you are out of work due to a work-related disability:

- **Notify your employer and the Fund Office.**
- **Contact your local workers' compensation office and apply for workers' compensation benefits.**

In the Event of Your Death

If you are an Active Member and eligible for coverage on the date of your death, your beneficiary is eligible to receive a Death benefit. If your death was due to an accident, your beneficiary may also be eligible to receive AD&D benefits. Such death and/or AD&D claims must be filed by your beneficiary within 24 months from the date of death. See pages 72-74 for more information about Death and AD&D benefits.

In the event of your death, your Spouse or beneficiary should:

- **Notify the Fund Office as soon as possible.**
- **Provide the Fund Office with a copy of your death certificate.**
- **Apply for Death benefits (and AD&D, if applicable).**
- **If your dependents want to continue coverage under the Plan, enroll for COBRA continuation coverage.**

For Active Members

If you die while an Active Member, coverage for your eligible dependents will be continued until the last day of the month in which your eligibility would have continued had you not died. Under a special Plan rule, widowed Spouses currently have the option of continuing self-pay coverage beyond the normal 36 month COBRA period for themselves and any eligible dependent(s), until they become eligible for Medicare or an employer-sponsored group health plan, they fail to pay a required premium on time, they die, or this special Plan rule is terminated.

Your Spouse and/or eligible dependents may continue health care coverage for up to 36 months by electing COBRA continuation coverage and making the necessary self-payments (see page 32).

When You Leave Covered Employment

COBRA Continuation Coverage

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly known as “COBRA”). COBRA continuation coverage can become available to you when you would otherwise lose your Plan coverage. It is also available to other members of your family who are covered under the Plan when they would otherwise lose their coverage. COBRA continuation coverage is not free, the Fund charges an applicable monthly premium as permitted by law and individuals on COBRA must be sure the Fund receives the monthly premium on time. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Fund Office.

When your COBRA continuation coverage ends, you will be provided with a Certificate of Creditable Coverage showing your length of coverage under the Plan. This may help reduce or eliminate any otherwise applicable pre-existing condition limitation under a new group medical plan.

If you have a newborn child, adopt a child or have a child placed with you for adoption or legal guardianship while COBRA continuation coverage is in effect, you may add the child to your coverage. You must notify the Fund Office in writing of the birth or placement and provide a completed enrollment form and other necessary documentation. (i.e., birth certificates, legal documents) in order to have this child added to your coverage. Children born, adopted or placed for adoption or legal guardianship as described above have the same COBRA rights as a spouse or dependents who were covered by the Plan before the event that triggered COBRA continuation coverage. Like all qualified beneficiaries with COBRA continuation coverage, their continued coverage depends on timely and uninterrupted payments on their behalf.

COBRA Continuation Coverage In General

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your eligible children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

Type of coverage. If you choose COBRA continuation coverage, you will be entitled to the same type of coverage that you had before the event that triggered COBRA. This includes medical, dental, prescription drug, vision and member-assistance benefits. ***However, COBRA coverage does not include Death, Accidental Death and Dismemberment, or Weekly Disability benefits. See pages 71-73 for more details.***

Cost of coverage. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. The Fund is permitted to charge the full cost of coverage for similarly situated employees and dependents (including both the Fund’s share and the employee’s share, if any) plus an additional 2%. If the 18-month period of COBRA continuation is extended because of disability, including being deemed disabled by Workers’ Compensation, the Fund is permitted to charge the full cost of coverage for similarly situated employees and dependents (including both the Fund’s share and the individual’s share, if any) plus an additional 50% for COBRA family members that include the disabled person for the 11-month disability extension period. The cost for COBRA normally stays the same for each calendar year, but it may change from year to year or as otherwise provided by law.

Qualifying Events

For an Active Member, you will become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events happens:

- Your hours of work in Covered Employment are reduced;
- Your employment ends for any reason, other than your gross misconduct (including a Termination for Cause); or
- You retire.

If you are a Spouse covered under the Plan, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse's (i.e., the Active Member's) hours of work in Covered Employment are reduced;
- Your spouse's employment ends for any reason, other than your spouse's gross misconduct (including a Termination for Cause);
- Your spouse retires;
- Your spouse dies;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your child(ren) will become qualified beneficiaries if they lose coverage under the Plan because of any of the following qualifying events happens:

- Your (i.e., the Active Member's) hours of work in Covered Employment are reduced;
- Your employment ends for any reason, other than your gross misconduct (including a Termination for Cause);
- You retire;
- You die;
- You become entitled to Medicare benefits (under Part A, Part B or both); or
- The child ceases to meet the definition of a "Child" under the Plan.

If your child is covered by a Qualified Medical Child Support Order (QMCSO), the child will be offered the same COBRA rights as other dependents if a qualifying event described above

occurs. Notices will be sent to such a child in care of the custodial parent.

If you enter the service in the Uniformed Services as defined by the Uniformed Services Employment and Reemployment Rights Act (USERRA) for at least 30 days, your service may be considered a qualifying event under COBRA if it causes the loss of your Fund coverage due to a reduction in hours or end of employment. You, along with any dependents, are entitled to elect to make self-payments for COBRA coverage, regardless of any coverage provided by the military or government.

When COBRA Coverage Is Available

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office becomes aware that a qualifying event has occurred.

The Fund will also offer COBRA continuation coverage to a former Active Member or a former Eligible Dependent in the event that he or she loses coverage due to engaging in Non-Covered Employment. COBRA is not available to those who lose Fund coverage due to a Termination for Cause.

The Fund Office is normally aware of most Qualifying Events

Since our Fund is a "multiemployer" fund, meaning a central fund to which several employers submit hours information and contributions, the Fund Office will normally be aware of qualifying events, which involve the end of employment, including retirement, or a reduction in the hours of your employment. Also, while we are normally notified of an employee's death (via a contributing employer or the employee's family) or an employee becoming entitled to Medicare benefits, *on occasion*

the Fund Office is not made aware of such instances. So, we would **strongly** recommend that the Fund Office be contacted in any case involving an employee's death or when an employee becomes entitled to Medicare. Once we become aware of one of these qualifying events, we will send along the applicable COBRA election package.

However, Other Individuals Must Give Notice Of Certain Qualifying Events

For the other qualifying events (a Spouse's divorce or legal separation, and a child ceasing to meet the requirements for dependent eligibility under the Plan), the Active Member or a qualified beneficiary ***must notify the Fund Office in writing within 60 days of the later of:*** (1) the date the event takes place, or (2) the date the person would lose coverage because of such change. The written notice must be provided to:

***COBRA Coordinator
International Union of Operating Engineers
Local No. 478
Health Benefits Fund
1965 Dixwell Avenue
Hamden, CT 06514-2400***

***Tel: (203) 288-9261 or (866) 288-9261 (toll free),
ext. 253***

Fax: (203) 281-3894

The failure to notify the Fund Office of such an event on a timely basis will result in the loss of the right to elect COBRA.

How COBRA Coverage Is Provided

Assuming any required notice and elections are made on a timely basis, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

Length Of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is due to end of employment or a reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In cases of qualifying events due to death, entitlement to Medicare benefits (qualified for and enrolled in coverage under Part A, Part B, or both), divorce or legal separation, or a child ceasing to meet the requirements for dependent eligibility under the Plan, coverage generally may be continued for up to a total of 36 months.

When the qualifying event is the end of employment or a reduction in hours of employment, and the former employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the former employee will generally last until 36 months after the date of Medicare entitlement.

In addition, there are two other ways in which the 18-month period of COBRA continuation coverage period mentioned above can be extended. These are explained in the very next section.

Disability Extension Of 18-Month Period of Continuation Coverage

An 11-month extension of COBRA (after the initial 18-month period) may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled, or if the former employee is determined to be totally disabled under Connecticut's Workers' Compensation Commission (WCC). Any SSA disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of coverage, while a WCC

disability must occur within the 18-month period of coverage. To qualify, the Fund Office must be provided with: (i) a copy of the SSA's written determination of disability within 60 days after the date such written determination was issued and before the end of the initial 18-month period, or (ii) proof of total disability of the former employee as determined by the WCC before the end of the initial 18-month period. The Fund Office must also be notified within 30 days of the date that the SSA determines that the applicable qualified beneficiary is no longer disabled. Any notice required under this extension must be provided to the Fund Office at the address listed on page 2.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If a specific second qualifying event occurs during the first 18 months of COBRA continuation coverage which is due to reduction in hours worked or the end of employment, then your spouse and the children in your family can get an 18 month extension of COBRA continuation coverage. The maximum amount of COBRA coverage available when such a second qualifying event occurs is 36 months from the date of the first qualifying event. Such second qualifying events may include:

- Your death;
- You become entitled to Medicare benefits;
- You get divorced or legally separated from your Spouse; or
- A child ceases to meet the requirements for dependent eligibility under the Plan.

The extension is available only if the event would have caused your spouse or eligible child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you must make sure that the Fund Office is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Fund Office at the address listed on page 2.

Can COBRA End Early?

Yes. COBRA can end early for any qualified beneficiary on:

- The date the Plan terminates;
- The first day of any month for which a COBRA premium is not paid on time;
- The first date after electing COBRA on which the qualified beneficiary becomes covered under another group health plan (provided that this rule will not apply if the other plan has a pre-existing condition exclusion which affects such qualified beneficiary); or
- The first date the qualified beneficiary engages in any conduct which constitutes a Termination for Cause.

IMPORTANT

Once Your COBRA Coverage Ends, It Cannot Be Reinstated.

Once I receive the COBRA forms, what should I do?

- Complete the COBRA election package and return it to the Fund Office as quickly as possible; and

- At the very least, include the initial self-pay COBRA premium payment. The initial self-pay premium must ***be received by the Fund Office with 45 days of your COBRA election. Thereafter, monthly COBRA premiums must be received by the first day of the month for which coverage is provided (subject to a grace period permitted by law).***

Failure to submit a properly completed election package on a timely basis will result in the loss of your right to COBRA, as will the failure to make a timely COBRA premium payment. Again, once you lose your COBRA coverage, it cannot be reinstated.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA's Web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's Web site.)

Keep Your Plan Informed Of Address Changes

To protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

Serving in the Uniformed Services

If you are called into the uniformed services (active duty or inactive duty training), you may elect to continue your health coverage, as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are called to military service:

- **Notify your employer and the Fund Office.**
- **Make self-payments if you wish to continue your coverage.**

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty for training;
- Inactive duty training;
- Full-time National Guard duty; and
- A period for which you are absent from a position of employment for an examination to determine your fitness for duty.

If you elect to continue coverage and you are in the uniformed services for less than 31 days, you must pay your share, if any, of the cost of coverage. If your service continues for more than 31 days, you may elect to continue coverage

under the Plan by making monthly self-payments. Your coverage will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 24 consecutive months after your coverage would have otherwise ended.

However, your coverage will end at midnight on the earliest day:

- Your coverage would otherwise end as described above;
- Your former employer ceases to provide any health plan coverage to any employee;
- Your self-payment is due and unpaid; or
- You again become covered under the Plan.

Your coverage ends on the first day of the month following the date you enter Uniformed Services and elect not to continue coverage. Your eligible dependents may continue coverage under the Plan by electing and making self-payments for COBRA continuation coverage.

Reemployment

Following your discharge from service, you may be eligible to apply for reemployment with your former contributing employer in accordance with USERRA.

You need to notify the Fund Office in writing when you enter the military and when you return to Covered Employment. For more information

about continuing coverage under USERRA, contact the Fund Office.

Reinstating Your Coverage

Following discharge from military service, you may apply for reemployment with your former employer in accordance with USERRA. Reemployment includes the right to elect reinstatement in the existing health coverage provided by your employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service.

When you are discharged or released from military service that was:

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

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

Family and Medical Leave Act (FMLA)

If you and your spouse both work for the same employer, you and your spouse are eligible for a combined total of 12 weeks of leave during a 12-month period.

The Family and Medical Leave Act (FMLA) of 1993 allows you to take up to 12 weeks of unpaid leave for your serious illness, to care for a child after the birth, adoption or placement for adoption of a child, or to care for your seriously ill spouse, parent or child. The Family and Medical Leave Act requires employers to maintain health coverage under any health plan for the length of a leave as if you were still employed. In addition, the Act states that if you take a family or medical leave, you may not lose any benefits that you had accrued before the leave.

Please note that if FMLA rights and benefits apply to you, you must work with your employer to take advantage of those rights and benefits. We are providing this information to you simply to make you aware of your FMLA rights.

Eligibility

To be eligible for FMLA benefits, you must:

- Work for a participating employer;
- Have worked for the employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and

- Work at a location where at least 50 employees are employed by the employer within 75 miles.

If you and your employer have a dispute over your eligibility and coverage under the Family and Medical Leave Act, your benefits will be suspended pending resolution of the dispute. The Fund and its Board of Trustees have no direct role in resolving such disputes.

Leave Entitlement

An employer covered under FMLA may grant you up to a total of 12 weeks of unpaid leave during any 12-month period for one or more of the following reasons:

- For the birth or placement of a child for adoption or foster care;
- To care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- To take medical leave when you are unable to work because of a serious health condition.

Leave for birth or adoption (including foster care placement) must conclude within 12 months of the birth or placement.

Spouses employed by the same employer are jointly entitled to a **combined** total of 12 weeks of family leave for the birth, placement of a child for adoption, foster care, or to care for a child or parent (but not parent-in-law) who has a serious health condition.

Under some circumstances, you may take FMLA leave intermittently, which means taking leave in blocks of time, or by reducing your normal

weekly or daily work schedule. Intermittent FMLA leave for birth or adoption or foster care placement requires your employer's approval. FMLA leave may be taken intermittently whenever it is medically necessary to care for a family member's serious health condition, or because you have a serious health condition and are unable to work.

Maintenance of Health Benefits

A covered employer is required to maintain the same health coverage for you on FMLA leave as the coverage that was provided before the leave was taken and under the same terms as if you had continued work. Therefore, an employer covered under FMLA must continue to make contributions on your behalf while you are on FMLA leave as though you had been continuously employed.

IMPORTANT

The Fund's Board of Trustees does not have the authority to force your employer to continue making contributions on your behalf while you are on FMLA leave. If you need assistance, contact the Wage and Hour Division of the U.S. Department of Labor (DOL).

Returning to Work

Upon return from FMLA leave, you must be restored to your original job, or to an equivalent job with equivalent pay, benefits, and other employment terms and conditions. In addition, your use of FMLA leave cannot result in the loss of benefits that you earned or were entitled to before using FMLA leave.

Termination of FMLA Health Care Coverage

Health care coverage during an FMLA leave ends on the earliest of the following dates:

- When you return to work; or
- When 12 weeks of leave ends.

FMLA and Other Benefits

You will not accrue additional benefits during an unpaid FMLA leave, but you cannot lose benefits you had accrued before your leave. Welfare benefits other than health care must be reinstated when you return to work without any new conditions or the need to meet eligibility requirements.

How FMLA Works with COBRA

Taking a family or medical leave is not itself considered a COBRA qualifying event. If you return from leave within 12 weeks, there will not be a loss of coverage.

If you do not return from leave, that is considered a COBRA qualifying event (a reduction in hours causing a loss of coverage). You will have up to 12 weeks of maintained health care coverage during FMLA leave and an additional 18 months (or 36 months, if applicable) of continued coverage under COBRA.

Taking an FMLA Leave

If you need to take an FMLA leave, your employer may require you to provide:

- 30-day advance notice of the need to take the FMLA, if the need is foreseeable;
- Medical certifications supporting the need for leave due to a serious health condition affecting you or an immediate family member;
- Second or third medical opinions and periodic recertification's (at your employer's expense); and

- Periodic reports during FMLA leave regarding your status and intent to return to work.

When leave is needed to care for an immediate family member or your own illness, and is for planned medical treatment, you must schedule treatment so that it will not unnecessarily disrupt your employer's operation. You and your employer must certify to the Trustees, in writing, that you have been granted leave under the Family and Medical Leave Act.

When You Retire

Assuming you have regular Active eligibility that extends into the future, coverage for you and your eligible dependents will end under the Active Plan at the end of the first month during which you receive I.U.O.E. Local No. 478 Pension Fund benefits. If, however, you qualify for and elect retiree medical benefits, that coverage will start when your Active eligibility ends, i.e. one month after your Retirement Effective Date. We strongly encourage you to consider the impact of your retirement from the I.U.O.E. trade (usually by retiring from the I.U.O.E. Local No. 478 Pension Fund) on your eligibility for retiree medical benefits from this Fund! The two basic rules to qualify for such retiree coverage are that you must:

- (1) retire from the I.U.O.E. trade having attained **at least age 60**, and
- (2) have had coverage (either regular or COBRA) under the Active Plan within 12 months of your initial retirement date (i.e., the date your pension benefits first began).

The rule in (2) of "12 months" is changed to "24 months" for those who are receiving a Disability Pension from the I.U.O.E. Local No. 478 Pension Fund. Also, there are a number of other special rules much too lengthy to mention here, but they generally relate to those who: (a) initially

retired from the I.U.O.E. trade prior to age 60, or (b) receive their retirement benefits from a contributing employer's retirement plan or the Officers and Employees of Local No. 478 and Funds' Employees Pension Fund.

If you have any questions regarding the Fund's retiree program eligibility rules, you should always contact the Fund Office for more information. If you are an Active Member, and lose eligibility for Active Plan coverage due to retirement and do not meet the eligibility requirements for retiree coverage, you may be eligible for COBRA continuation coverage.

When you retire:

- **Notify the Fund Office in advance of your retirement.**
- **Apply for retiree benefits if you are eligible.**
- **If you want to continue coverage under the Plan, enroll for COBRA continuation coverage, unless you qualify for retiree coverage.**

Returning to Work

For Employees

If your eligibility ends and you start working again for an employer who contributes to the Fund, you must once again meet the initial eligibility requirements before you will be eligible for Plan benefits.

If you return to work following a military leave of absence, your coverage will be reinstated as described on page 37.

Medical Benefits

The Plan offers comprehensive health care coverage to help you and your eligible dependents stay healthy and to help provide financial protection against catastrophic health care expenses.

FAST FACTS

- The Plan uses a Preferred Provider Organization (PPO)—a network of physicians and hospitals that have agreed to provide services at discounted rates.
- The Plan pays a higher percentage of your medical expenses if you visit an in-network (PPO) provider.
- You do not need to meet a deductible when you visit PPO providers.



How the Plan Works

Preferred Provider Organization (PPO)

To help manage certain health care expenses, the Plan contains a cost management feature—the Preferred Provider Organization (PPO). A PPO is a network of physicians and hospitals that have agreed to charge negotiated rates. When you use a PPO provider, you save money for yourself and the Plan because the PPO provider has agreed to charge a discounted dollar amount. The Fund currently utilizes Anthem Health Plans, Inc. (d/b/a Anthem Blue Cross and Blue Shield) or “Anthem” as its PPO.

It’s your decision whether or not to use a PPO provider. You always have the final say about the physicians and hospitals you and your family use. To encourage you to use PPO providers whenever possible, the Plan pays a higher percentage of covered expenses when you use a PPO provider. If you have questions, or need a listing of physicians and hospitals that participate in the PPO network (provided free of charge), see page 5 for PPO contact information.

The Plan pays different levels based on whether you use a PPO or non-PPO provider as listed in the “Schedule of Benefits” on page 7. ***You must show your ID card each time you receive medical care, otherwise, your expenses may be paid as non-PPO expenses, even if you use a PPO provider.***

Note that some expenses may be covered differently or subject to different benefit maximums. See the “Schedule of Benefits” on page 7 for more information.

Preferred Provider Organization (PPO)

A PPO is a network of health care providers who have agreed to charge negotiated rates. Since PPO providers have agreed to these negotiated rates, you help control health care costs for yourself and the Plan when you use PPO providers.

Please keep in mind that when you visit a PPO hospital, the physicians and other health care providers in the hospital may not belong to the PPO network, and vice versa.

Deductible (Out-of-Network Only)

You are **NOT** responsible for meeting a deductible when you visit a PPO provider. However, if you visit an out-of-network provider, you must meet a calendar year deductible before the Plan begins to pay benefits for non-PPO provider services.

The deductible applies to each covered person each calendar year for certain benefit types (for example, there is a deductible for out-of-network hospital benefits, but not for out-of-network ambulance charges). The family deductible is met once two or more eligible individuals in a family meet the amount as shown in the “Schedule of Benefits” for the family maximum. Once the individual and/or family deductible is met, no further deductibles are required for that year.

Make The Call

If you need inpatient mental health or substance abuse treatment, you must call the Plan’s Gatekeeper to get your care, or that of an eligible dependent, precertified. If you do not make this call, the expenses may not be covered. See page 5 for contact information. You must call MHN within 72 hours of your admission.

When you need to see a doctor...

- **Call to make an appointment.**
- **Write down any health-related questions you have before your appointment. This way, you will not forget to ask your doctor important questions during your appointment.**
- **Make a list of any medications you’re taking. Be sure to note how often you take the medication.**
- **Show your Health ID card when you go to your appointment to ensure your doctor knows where to file your claim.**
- **Consider asking your doctor for samples of any prescription medication you may need.**

Behavioral Health/Substance Abuse Precertification

The Plan offers a precertification program that specializes in helping you receive quality treatment, and at the same time, helping you maximize your Plan benefits. You or your doctor need to contact MHN at the number listed in “Contact Information” on page 5 before receiving any **inpatient** mental health or substance abuse treatment. You must call within 72 hours of your admission, or the admission of an eligible dependent. If you do not pre-certify your treatment, or that of an eligible dependent, the expenses may not be covered. Please refer to the “Schedule of Benefits” on page 7 for further details.

Coinsurance/Copayment

For PPO-network services, you are not responsible for meeting a deductible. You simply make your copayment (in most cases, \$25) and the Plan pays the remaining covered expenses. In some instances, such as for hearing aids or medical equipment and supplies, you may be responsible for paying 10% of the covered expenses. This is called “coinsurance.”

If you visit an out-of-network provider for services, you must meet a deductible each year before the Plan will begin to pay for covered expenses for certain benefit types. Once you or your family has met the annual deductible, the Plan pays a percentage of covered expenses, called “coinsurance.” The amount the Plan pays depends on the type of covered expense as listed in the “Schedule of Benefits” on page 7. For most covered services, this amount is 80%, subject to the Maximum Allowable Cost (MAC) limitation, as explained on page 44. Your payment is the remaining 20%.

Reimbursement for Certain Out-of-Network Services (Special Reimbursement Rule)

We understand that at times, it is not possible for you or an eligible dependent to receive services from a PPO provider. In the circumstances listed below, if you receive or an eligible dependent receives services from an out-of-network provider the Plan will pay 90% with no deductible and the allowance for claims will be reimbursed according to the Reasonable and Customary allowance for non-network providers.

- Your eligible child resides temporarily outside the PPO’s service area while attending college, or while covered under a QMCSO, and the child requires medically necessary care.
- The eligible individual was outside the PPO’s service area and required medically necessary care due to a life-threatening emergency medical situation.
- The eligible individual initially received medically necessary care in a PPO facility or from a PPO provider, but an out-of-network provider was required to provide certain ancillary medically necessary covered services which were related to service provided by the PPO facility or provider. Examples here are ancillary services provided in connection with an emergency room visit, pathology or laboratory analysis, and radiology, anesthesia, or assistant surgery services.
- The eligible individual receives ancillary medically necessary care (such as lab or X-rays) from an out-of-network provider, but solely in instances where the eligible individual had no part in, or control over, the decision of whether to use such out-of-network provider.

- The eligible individual receives medically necessary care from an out-of-network provider and the Fund's Medical Consultant confirms to the Fund that there are not a sufficient number of PPO providers in the PPO's service area who had the necessary qualifications in the specialty and/or practice to perform such care at the time it was rendered.
- The eligible individual receives medically necessary care from an out-of-network provider and the Fund's Medical Consultant confirms to the Fund that there was a lack of availability of PPO providers to perform such care at the time it was rendered.

If you think this special reimbursement rule applies to a claim of yours or an eligible dependent, ***please contact the Fund Office.*** This is because the Fund Office will normally not know of the circumstances surrounding a particular claim unless you inform us.

Annual and Lifetime Maximums

You and each eligible dependent can receive medical benefits up to the annual and lifetime maximums specified in the "Schedule of Benefits" on page 7. Certain services have separate annual and/or lifetime maximums.

As required by the Patient Protection and Affordable Care Act of 2010, the Plan does not have any lifetime maximums on Essential Health Benefits, and it has limited annual maximums on Essential Health Benefits for a limited time period (January 1, 2011 through December 31, 2013). On and after January 1, 2014, the Plan will not impose any lifetime or annual limit on Essential Health Benefits. To the extent the Plan otherwise maintains a lifetime or annual limit, the reason for that is because the benefit is a Non-Essential Health Benefit. See the definitions on page 107

for information on Essential and Non-Essential Health Benefits.

Reasonable and Customary/MAC Expenses

The Plan pays most benefits only to the extent that they are "reasonable and customary." We normally call this the Maximum Allowable Cost or "MAC." In general, this is the amount providers most frequently charge for the same service or procedure in a geographic area. Reasonable and customary/MAC expenses are determined by the Trustees who may rely on the advice of medical professionals. The discounted rates charged by PPO providers are considered reasonable and customary by the Plan. For expenses incurred by a non-PPO provider, you are responsible for amounts over reasonable and customary/MAC expenses.

Medically Necessary

The Plan pays benefits only for services and supplies that are medically necessary. In general, "medically necessary" means a service, supply, treatment, or hospitalization that:

- Is essential for the diagnosis or treatment of the injury or illness for which it is prescribed;
- Meets generally accepted standards of medical practice; and
- Is ordered by a physician.

Services, supplies, treatment, or hospitalization are not considered medically necessary if they are:

- An Experimental Procedure or primarily limited to research in their application to the injury or illness;

- Primarily for scholastic, educational, vocational, or developmental training; or
- Primarily for the comfort, convenience, or administrative ease of the provider, patient, or his or her family or caretaker.

The Trustees, in consultation with the Fund’s health consultants reserve the right to review medical care and to make determinations as to whether any service, supply, or treatment is medically necessary. The fact that a physician or any other health care provider (including one in the Fund’s PPO) prescribes services or supplies does not automatically mean the services or supplies are medically necessary and covered by the Plan. The same principles would apply in determining whether a prescription drug is covered by the Plan.

Your Responsibilities

It is important to remember that this Plan is not designed to cover each and every health care expense you or your dependents may incur, nor is it designed to pay for 100% of all medical costs. The Fund has finite resources, and it pays for medically necessary covered expenses, up to the limits, and under all of the terms and conditions, established under the rules of the Plan. The decisions about how and when you receive medical care are up to you and your physician—not the Plan. The Plan determines how much it will pay; you and your physician must decide what medical care is best for you.

Another point we must stress is only the full Board of Trustees has the authority and discretion to interpret the Plan and the terms of this booklet. You should not rely on any statement or opinion from a medical provider, the Fund’s PPO network, or any other individual or entity about whether you (or a family member) is covered and/or what benefits the Plan provides.

EXAMPLE

You are a Member who is covered under the terms of the Fund. Your physician recommends a particular treatment for you, and in discussing the treatment with your physician she indicates that the treatment is mandated by Connecticut’s health insurance laws. Based on this, is it safe for you to assume that the Fund covers this treatment? The answer is no! Our Fund is governed by federal law, and as a result our Fund is not governed by these Connecticut laws.

There are many other examples similar to the above, but we can’t possibly mention them all. The bottom line is that ***if there is ever a doubt in your mind about whether you or a family member is covered, or what coverage the Fund provides, always contact the Fund Office for guidance or an official opinion.***

Wellness Benefits

The Plan provides coverage for certain preventive care benefits to help keep you and your eligible dependents healthy. Covered preventive care includes expenses incurred for services and supplies in these broad categories:

- Routine physical examinations;
- X-ray services;
- Various laboratory services;
- Certain screening mammograms;
- Well baby care for infants;
- Well child care for children through age 26; and
- Various immunizations.

See the “Schedule of Benefits” on page 7 for specific age limits and Plan rules and limitations for wellness benefits.

Reasonable and Customary Charge (also known as MAC)

The reasonable and customary charge, or MAC, means only the charge incurred, or portion of the charge, for medical or dental care, services and supplies that is not in excess of the customary charge for the same or similar care, services and supplies compared to fees generally charged for comparable places where the services were received.

Hospital Benefits

Benefits will be paid for you or your eligible dependents for charges actually made by a hospital while hospitalized. In- and out-of-network claims are payable in the amounts and subject to limits as listed in the “Schedule of Benefits.”

Charges for a hospital emergency room or an emergency walk-in center for emergency service or treatment provided as a result of surgery or as a result of injury will be payable as a hospital benefit in the amounts listed in the “Schedule of Benefits,” even though you were not hospitalized, provided you are admitted as an in-patient within 24 hours of the treatment for the same illness.

Hospitalization must be recommended by a physician, and there is currently a \$105 copayment that you would pay per admission.

Hospital charges for surgical, dental (unless accidental injury to natural teeth), nursing, or physician’s fees are excluded.

CHOOSING A PHYSICIAN

You save money for yourself and the Plan when you use a physician who participates in the Plan’s PPO.

One way to find a physician is to ask around. Ask a family member, friend, or co-worker if they have the name of a physician they would recommend. With the enactment of the federal health care law in 2010, we expect Web sites will be developed which will allow you to compare doctors. Such a site already exists for doctors enrolled in Medicare (<http://www.medicare.gov/find-a-doctor/provider-search.aspx>). Before visiting a physician, you should contact the PPO (see page 5 for PPO contact information) to ensure your physician is in the PPO.

Here are some questions you may want to ask the physician(s) you’re thinking about making an appointment with:

- Are you accepting new patients?*
- What’s your treatment style?*
- Are you board certified? If so, in what specialties? (Any physician with a license can practice in any specialty. Board certification is your assurance that the physician has appropriate training for the specialty.)*
- At which hospitals do you admit patients for major health care needs? Does the hospital belong to the PPO network? Do the hospital technicians (for example, for laboratory tests and X-rays) belong to the PPO network?*
- What are your office hours?*
- On average, how long do patients have to wait to make an appointment?*
- During an appointment, on average, how long is the wait in your waiting room?*

Surgical Benefit

Surgical benefits are divided into two categories—*major and minor*.

Major Surgery

Major procedures are those that have a negotiated fee or reasonable and customary (MAC) fee of \$800 or more. If you visit a PPO provider for your surgery, there is a flat \$105 copayment per operation. Additional copayments apply to assistant surgeons, anesthesiologists and the hospital or surgi-center.

If you visit an out-of-network provider, you are responsible for meeting your deductible first, and then paying 20% of the reasonable and customary (MAC) charges for covered services. If your out-of-network provider charges more than the reasonable and customary (MAC) amount, you will be responsible for paying the difference in addition to your 20% coinsurance.

Minor Surgery

Minor procedures are those with a negotiated fee or MAC fee of less than \$800. If you visit a PPO provider for your surgery, there is a \$25 flat copayment per procedure. The Plan pays 100% of covered expenses after you've met your copayment.

If you visit an out-of-network provider for your minor surgery, you are responsible for meeting your deductible first, and then paying 20% of the reasonable and customary (MAC) charges for covered services. If your out-of-network provider charges more than the reasonable and customary (MAC) amount, you will be responsible for paying the difference in addition to your 20% coinsurance.

Surgery performed in remote operative fields at the same operative session will be paid in the same manner as described above. The Plan also has the following rules to determine if one or multiple surgical procedures have occurred:

- Successive surgical procedures for the same injury or illness are considered as one surgical procedure unless the subsequent procedure is performed after a complete recovery from the injury or illness causing the prior surgery, or is due to a cause or causes entirely unrelated to the cause or causes of the prior surgery.
- Successive surgical procedures for an Active Member for the same or related injury or illness as a prior surgery are considered a new surgery if such Active Member had returned to work in Covered Employment after the surgery and completed at least one working day (8 hours), or if the surgeries are separated by at least 90 days.

Any surgical procedure must be recommended and performed by a physician. No benefit will be paid for surgical charges other than the physician's fee or for follow-up visits by the operating surgeon during the follow-up period. The follow up period will be determined in consultation with the Fund's medical consultant.

Maternity and Obstetrics Benefit (Including Infertility)

Pregnancy Benefit

The Plan will pay for covered charges for pregnancy-related medical treatment for you or your Spouse, as it would for any other illness in the amounts and subject to the limits listed in the "Schedule of Benefits." The Plan will pay the charges made by a licensed nurse-midwife related

to the delivery of a child up to the limits listed in the “Schedule of Benefits.” Eligible children are generally not eligible for these benefits, except in limited situations where the Member (through whom the particular child has coverage) is a legal resident of Massachusetts. This particular exception is in place to comply with certain Massachusetts “minimum creditable coverage” laws. There is another exception where a female child may be covered for maternity coverage if she is purchasing COBRA Continuation Coverage on an individual basis.

Newborns’ and Mothers’ Health Protection Act of 1996:

The Plan complies with this federal law by not restricting benefits for any hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, this law generally 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 48 hours (or 96 hours if a C-section was performed). In addition, the Plan does not require that a hospital or physician obtain authorization from the Plan for prescribing a length of stay that does not exceed those time periods.

Infertility Benefit

The Plan will pay for infertility treatment for you or your Spouse as it would for any other illness or injury subject to the limits listed in the “Schedule of Benefits.” Eligible children are not eligible for this benefit. Prescription drugs for infertility are considered under the Plan’s prescription drug benefit.

Office Visit Benefit

The Plan will pay the covered charges made by a physician for medical treatments received by an eligible individual resulting from an injury or illness in the amounts listed in the “Schedule of Benefits” for each treatment by a physician. You or your eligible dependents are entitled to benefits for treatments beginning with the first treatment received for a covered injury or illness. All treatments received on any one day will be paid as a single treatment, except when treatment is given for an unrelated illness or injury, or when the eligible individual is required to be treated by more than one physician. The Plan will pay for as many separate and distinct illnesses or injuries as may occur.

The office visit benefits described in this section are payable on or after the date of a surgical procedure, except for treatments during the follow-up period by the surgeon who performed the operation.

Visits charged by the performing surgeon after a surgical procedure has been performed will be limited by the number of surgical follow-up days allowed. No office visit benefit will be paid under the Plan for charges incurred during the follow-up period. The follow-up period is determined in consultation with the Fund’s medical consultant. Visits after the follow-up period will be paid under the office visit benefit as described above.

Office visit benefits are not payable for treatments received related to any dental work or treatment, eye refraction, eyeglasses, contacts or their fittings and related follow-up visits, injections received to prevent an illness, for the treatment of weak, strained or flat feet or any metatarsalgia or bunion, or for the treatment of corns, calluses or toenails (but not excluding charges for partial or complete removal of nail roots) except related to

metabolic disease, such as diabetes or a peripheral vascular disease such as arteriosclerosis.

Charges for visual field examinations that are not performed with a medical office visit will not be paid.

Chiropractic/Massage Therapy Benefit

The Plan will pay the covered charges made by a physician, licensed Chiropractor, or licensed massage therapist for care related to the correction by normal or mechanical means of structural imbalance, or subluxation in the human body to remove nerve interference and their effects, where the interference is the result or related to distortion, misalignment, subluxation, or in the vertebral column subject to the limits listed in the “Schedule of Benefits.”

Please note that for licensed massage therapist charges, the Fund will only make payments if the licensed massage therapist performed the massage therapy services and such services were rendered due to a prior written recommendation of a physician or licensed Chiropractor.

Orthotics Benefit

The Plan will pay covered charges for orthotic devices prescribed by a physician, in the amounts listed in the “Schedule of Benefits.” The Fund Office will require a written prescription from the attending physician for each orthotic device.

Naturopath/Homeopath Benefit

The Plan will pay covered licensed naturopath or homeopath charges for services given by a naturopath or homeopath up to the amounts as listed in the “Schedule of Benefits.”

Psychiatric Office Visit

The Plan will pay covered licensed psychologist or psychiatrist charges or charges by a person

with a Masters Degree in Social Work for office visits for psychotherapy treatments and/or treatments for mental/nervous conditions or for alcohol and/or substance abuse conditions as listed in the “Schedule of Benefits.”

Physical Examination Benefit (Routine)

The Plan will pay covered physician charges for a medical examination you or your Spouse receive up to limits listed in the “Schedule of Benefits.” This includes charges for certain X-ray or laboratory expenses ordered during your examination. Eligible children are not eligible for this benefit, but we note that they are able to receive various Wellness Benefits described on page 45 and in the Schedule of Benefits.

Physical examination benefits are not payable for charges incurred related to any hearing examination or appliance, any dental work or treatment, eye refractions, eyeglasses or their fittings or injections to prevent illness.

Laboratory/X-Ray Benefit

The Plan will pay, covered laboratory or X-ray charges up to the limits listed in the “Schedule of Benefits,” except as listed below.

The following tests are covered when related to your eligible child’s well-child examination: tine test, urinalysis, HPV (females) and complete blood count, hemoglobin or hematocrit.

The following tests are covered when related to you or your Spouse’s routine physical examination and when performed in conjunction with well-child visits incurred by your eligible children: pap (females), cholesterol, thyroid screening and HPV (females).

X-ray and lab tests ordered with respect to actual or suspected diagnoses are also covered under this benefit.

No benefits are payable under this benefit for X-rays made without film, except fluoroscopy, or related to: dental work (except services related to temporomandibular joint dysfunction), any X-rays or laboratory work related to any illness or injury covered under the Plan's hospital benefit, or physical examinations covered under the physical examination benefit.

Miscellaneous Outpatient Benefits

The Plan will pay covered charges for various miscellaneous outpatient procedures related to treatment for you or your eligible dependent's covered illness or injury up to the limits listed in the "Schedule of Benefits." A few examples of benefits provided by the Plan under this category include:

- Outpatient radiation therapy;
- Cardiac rehabilitation;
- Outpatient dialysis and home IV therapy; and
- Various therapies (e.g., physical, speech and occupational) which are not otherwise covered under our Plan's Home Health Care benefit.

Hospice Services Benefit

The Plan will pay covered charges for you and your eligible dependents for hospice services given by or through a hospice up to the limits listed in the "Schedule of Benefits." To qualify for hospice services benefits, you or your eligible dependent must be terminally ill. Terminally ill means you are diagnosed as having 12 months or less to live by your attending physician.

Here are examples of charges the Plan will consider:

- Care in hospice facility or at home;
- Skilled nursing services and services given by a home health aide;
- Dietary and nutritional assistance;
- Physical, respiratory, and speech therapy;
- Ambulance or special transportation (between home or hospital to a hospice facility);
- Medical social services as described on page 51; and
- Other services and supplies given by a physician.

Home Health Care Benefit

The Plan will pay covered charges for you and your eligible dependents for home health care as the result of a covered Injury or Illness as listed in the "Schedule of Benefits."

The Plan will pay covered charges for you and your eligible dependents for home health care agency charges for services or supplies as listed below in the person's home in accordance with a home health care plan including:

- Skilled nursing services;
- Physical therapy, occupational therapy, speech therapy services provided by licensed therapists of the home health care agency;
- Part-time or intermittent home health aide care services, consisting primarily of patient care of a medical or therapeutic nature;

- Medical supplies, federal legend prescription drugs and medications prescribed by physician and laboratory services by a hospital, provided that drugs related to home health care benefits will be paid under this benefit to the extent they would have been paid under the prescription drug benefit provisions; and
- Medical social services provided to or for the benefit of you or your eligible dependents diagnosed by a physician as terminally ill. For this purpose, the term “medical social services” means services rendered, under the direction of a physician, by a qualified social worker holding a master’s degree from an accredited U.S. school of social work, such as: (1) assessing the social, psychological and family problems which relate to an eligible individual’s illness or injury and treatment, (2) recommending actions and use of any community resources to assist in resolving such problems, and (3) developing an overall treatment plan for the eligible individual.

The services described in this section are limited to **60 visits per Plan year**. Each visit by a member of a home health care team is considered one visit.

The Plan will pay the equivalent of the home health care benefit where you or your eligible dependent do not qualify for the rehabilitative nursing home benefit as described in the “Schedule of Benefits,” page 11, and have recovered sufficiently to be discharged from the hospital and, under the circumstances, could not be adequately cared for at home. In this case, the equivalent home health care benefit may be provided, subject to periodic review by the Trustees and the Fund’s medical consultant, subject to the limits listed in the “Schedule of Benefits.”

Mammography Benefit

The Plan will pay covered routine screening mammography charges for eligible adult females up to the limits listed in the “Schedule of Benefits.” Once an illness is diagnosed, any additional expenses are eligible for coverage under the applicable benefits in the Plan. Eligible children are not entitled to this benefit. Mammographies that are received related to an illness are covered under the laboratory/X-ray benefit.

Dietary/Nutritional Counseling Benefit

The Plan will pay covered office visit charges for dietary or nutritional counseling for you or your eligible dependents up to the limits listed in the “Schedule of Benefits.”

Routine Immunization Benefit

The Plan will pay covered charges for routine immunizations for you or your eligible dependents up to the limits listed in the “Schedule of Benefits.” The Plan looks at those immunizations recommended for an eligible individual by the Centers for Disease Control.

Conditional Immunizations

The Plan will pay covered charges for conditional immunizations as listed in the “Schedule of Benefits” for you or your eligible dependents who meet certain criteria—such as foreign travel or an individual who works in the healthcare field.

Organ and Tissue Transplant Benefits

The Plan will pay covered charges related to any organ or tissue transplant, including procurement of organs or tissue, received by you or your eligible dependents as listed in the “Schedule of Benefits.”

In order to receive organ and tissue transplant benefits:

- The transplant must be performed in accordance with an approved transplant center program in a medical center that has been approved for the procedure either by the federal government or the appropriate state agency of the center where the center is located.
- The transplant procedure must be recognized as reasonable and necessary in the Social Security Act for the specific condition involved, and therefore, covered under Medicare, and must not be considered as an Experimental Procedure.
- The physician must provide appropriate information to the Fund Office prior to the procedure (such as diagnosis, type of operation and treatment).

No benefits will be payable for:

- An organ or tissue transplant where the conditions under this benefit are not met or an organ or tissue procurement or organ or tissue transplant performed outside the United States;
- An organ or tissue transplant related to an injury or illness for which benefits are available through a government program, or would have been available if not for the Plan. A government program includes a local, state, federal, or foreign law or regulation that provides or pays for health services, but does not include Medicaid. Benefits will not be provided if you or your eligible dependent would have received benefits for the transplant from a government program had you or an eligible dependent applied for them in a timely manner;

- Expenses related to an organ or tissue transplant that were incurred by you or your eligible dependent before you or your dependent became eligible for benefits under the Plan;
- Cardiac rehabilitation services, other than such services furnished as a result of a heart or heart/lung organ transplant; or
- Expenses incurred as an organ donor, or in preparation of becoming an organ donor.

Hearing Aid Benefit

The Plan will pay covered charges for the amount charged for hearing examinations and appliances for you and your eligible dependents as outlined in the "Schedule of Benefits." There is a limit of ***one set of hearing devices (left ear and right ear) every 36 months.***

Engineers Family Assistance Program

The Engineers Family Assistance Program (EFAP) is administered by MHN and is designed to provide prompt, professional assistance for you and your eligible dependents for mental health related problems or other personal or family difficulties. Problems such as alcoholism, drug abuse, family situations, child and adolescent concerns, financial pressures, or job stress may disrupt you or your family's lives. The EFAP is an organization of physicians, social workers, counselors, psychologists, that provide you and your eligible dependents with professional assistance.

To receive benefits from the Fund for mental/nervous conditions or substance abuse treatment, you or your eligible dependent must contact the EFAP before receiving inpatient treatment, regardless if the Fund is a primary or secondary payer for services. However, the Fund will waive

this requirement when the Fund is secondary payer and the primary payer has a similar managed care program that you or your eligible dependent adheres to.

When you call EFAP a trained professional will help evaluate your situation, and, if necessary, refer you to the appropriate resource. If inpatient treatment is required, you will be referred to an approved EFAP facility. Benefits will be paid on emergency hospital admissions, if the hospitalization is reported to the EFAP within 72 hours of the admission, and an agreed upon length of stay is determined.

Benefits will be paid as listed in the “Schedule of Benefits.” If you do not use the EFAP for Inpatient care, benefits will not be paid for mental/nervous or substance abuse treatment. If you fail to follow the treatment plan, no further benefits will be paid. Outpatient care does NOT require prior authorization but, out of pocket savings may be greater if an MHN provider is utilized. Subject to the terms of this section and the “Schedule of Benefits,” court-ordered psychiatric and alcohol and substance abuse treatment will be covered to the extent there is no other entity responsible for payment (such as a governmental/administrative agency).

The following are not covered:

- Testing for purposes of psychological evaluation; and
- Methadone or methadone treatment programs.

To contact the EFAP, see the “Contact Information” on page 5.

Covered Medical Expenses

Covered medical expenses are the reasonable and customary (MAC) expenses actually incurred for the services, supplies, and types of treatment, which are medically necessary and are required in connection with the treatment of your or your eligible dependent’s injury or illness. If a charge is more than the reasonable and customary charge, only the reasonable and customary charge will be considered a covered expense. ***Please keep in mind that expenses relating to covered expenses will be paid according to the Plan’s deductibles, benefit maximums, limitations, and reasonable and customary expenses as shown in the “Schedule of Benefits” on page 7.*** The following expenses are considered covered medical expenses under the Plan.

1. Charges made by a hospital, provided that any applicable daily room and board charges may not exceed the hospital’s regular rate for semiprivate accommodations.
2. Charges for miscellaneous services and supplies furnished by the hospital.
3. Office visit charges for diagnosis, treatment, and surgery by a physician.
4. Charges for services rendered in the home by a nurse for private duty nursing service, other than a nurse who ordinarily resides in the eligible individuals home or who is a parent, sibling, child, or spouse of that eligible individual.
5. Charges for hearing examinations and appliances.

6. Charges for x-ray and laboratory services and the use of radium and radioactive isotopes, physiotherapy, and similar services and treatment.
7. Charges incurred for care or treatment of mental disorders, alcohol, or substance abuse treatment, including drugs and convulsive therapy while hospitalized.
8. Charges for prescription drugs and medicines and medical supplies, blood and blood plasma, and surgical dressings outside the hospital.
9. Charges made by a state licensed speech, physical, respiratory, or occupational therapist.
10. Charges for prosthesis, including artificial limbs or eyes, for the replacement of natural limbs or eyes, truss, brace or fixed support, including, but not limited to, corrective braces for eligible children.
11. Charges for administration of oxygen, and for the rental or purchase, whichever is less expensive, or an iron lung, a wheelchair, a hospital-type of bed or, in situations where an eligible child is diagnosed by a physician with autism or mucopolysaccharidosis and such diagnosis is confirmed by the Fund's Medical Consultant charges for an adjustable/ safety bed and mattress with Fund payments not to exceed \$2,080.
12. Charges for hospice services and home health care benefits.
13. Charges for well child care.
14. Charges for a diaphragm for eligible individuals,.

15. Charges for other items and services specifically mentioned as medical benefits in this Summary Plan Description.

Women's Health and Cancer Rights Act:

The Plan also complies with this federal law. Specifically, in connection with an eligible individual who is receiving Plan benefits for a mastectomy, and who elects (in consultation with their physician) breast reconstruction in connection with the mastectomy, the Fund will treat the following as covered expenses:

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

Coverage of such items are subject to all normal Plan rules (copayments, deductibles, etc.).

Medical Expenses Not Covered

You should be aware that not every medical expense is covered by the Plan. Below is a list of medical expenses the Plan does not cover:

1. Any procedure, treatment, service, or material listed under "General Plan Exclusions" on page 77.
2. Charges by a hospital owned or operated by the federal government, except as required by law.
3. Charges that you or your eligible dependent are not legally required to pay.

4. Charges for dental procedures except those preventative, restorative and implant services specifically covered under the dental care benefit.
5. Eye glasses, or their fitting (may be covered under the vision benefit).
6. Transportation, except as otherwise provided for ambulance services under the Plan.
7. Charges for any appliances or prosthetics not otherwise covered under the Plan.
8. Services provided by a private duty nurse while in the hospital.
9. Charges for ancillary vision services, such as visual training or orthoptics, provided fundus photography is covered when there is a diagnosis of retinal pathology.

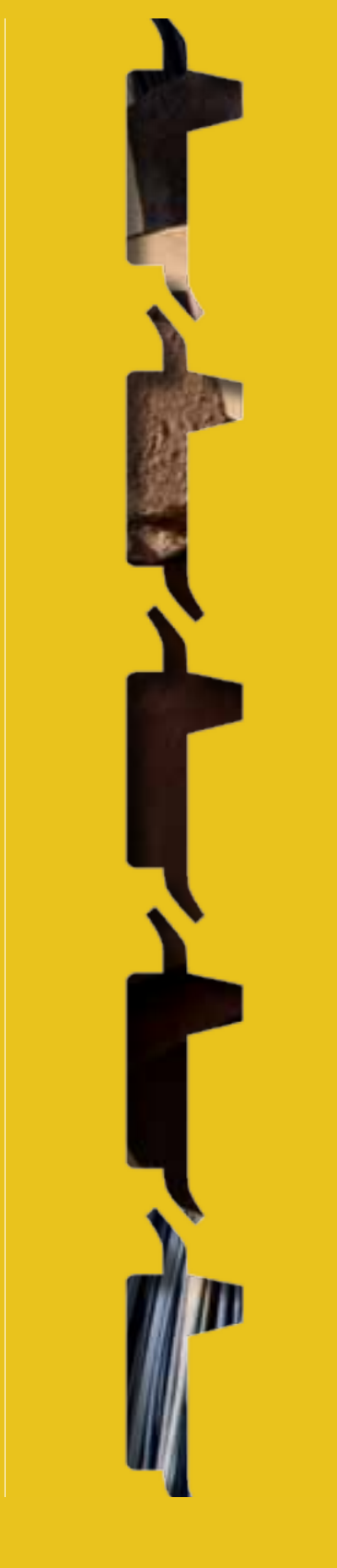


Prescription Drugs

Prescription drug coverage can play an important role in your overall health. Recognizing the importance of this coverage, the Plan has contracted with a network of preferred pharmacies through the prescription drug provider listed in “Contact Information” on page 5 (CVS Caremark). When you have your prescriptions filled at a network pharmacy, you save money for yourself and the Plan.

FAST FACTS

- Present your CVS/Caremark drug ID card at a participating pharmacy and make the applicable copayment to receive your prescription drugs.
- You can save time and money by using the mail order program. You can order a 90-day supply of generic prescription drugs for just \$25.
- Most prescription drugs have two names—the generic name and the brand name. Legally, both are required to meet the same safety, purity and effectiveness standards, so ask your doctor about whether a generic medication can be substituted for a brand name medication.



When You Fill Prescriptions at a Network Pharmacy

When you have a prescription filled at a network pharmacy, simply present your CVS/Caremark drug ID card and your prescription (unless it was submitted electronically or by phone). Then, you pay:

Prescription Drug Benefits	You pay:
Prescription Type	
Generic	Lesser of drug cost or \$15
Brand (Formulary)	Lesser of drug cost or \$30
Brand (Non-Formulary)	Lesser of drug cost or \$45

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If you have your prescriptions filled at a pharmacy that is not part of the network or you do not present your ID card to the pharmacist, you will not receive discounted medication prices.

If you have a prescription filled at a non-network pharmacy, you pay 100% of the undiscounted cost of the prescription. You will be reimbursed as listed in the “Schedule of Benefits.” To be reimbursed, submit your prescription receipt to the Fund Office with your name and your Fund Identification Number. Please note that prescriptions obtained at out-of-network pharmacies are generally paid at 80%.

NOTE

When you are 50% through your prescription, you can call CVS to initiate your re-fill.

For a listing of network pharmacies, contact the prescription drug network provider listed on page 5.

When you visit a retail pharmacy, you can normally get a 30-day supply of a prescription. Utilizing the mail-order program allows you to get up to a 90-day supply of a prescription at one time, usually at a lower cost than if you bought three monthly purchases of the same drug at the pharmacy.

When You Fill Prescriptions Through the CVS/ Caremark Mail-Order Program

You should use the CVS/Caremark mail-order program when you need to have prescriptions filled for maintenance medications. When you order by mail, you can normally get up to a 90-day supply at one time. Also, the Fund utilizes CVS/Caremark’s “Maintenance Choice” program. This program allows you to receive 90-day supplies of maintenance medications either

through the mail-order program *or via pick-up only at a CVS pharmacy at the same co-payment. Please note that under this program, 30-day supplies of maintenance medications will have a two (2) refill limit, before having to switch to mail order as the Plan is strongly encouraging the use of 90-day supplies.*

The following copayments apply for the CVS/ Caremark Mail Order Program:

Prescription Drug Benefits	You pay:
Prescription Type	
Generic	Lesser of drug cost or \$25
Brand (Formulary)	Lesser of drug cost or \$55
Brand (Non-Formulary)	Lesser of drug cost or \$85

Maintenance Medications are prescription drugs that are used on a long-term or on-going basis. These prescriptions can be used to treat chronic illnesses such as:

- Arthritis;
- Diabetes;
- Emotional distress;
- Heart disorders;
- High blood pressure; and
- Ulcers.

Specialty Drugs

Those injectables and other biotech drugs commonly referred to as “specialty” drugs are obtainable exclusively through CVS/Caremark. This is often referred to as CVS/Caremark Specialty Pharmacy and CarePlus pharmacy. These “specialty” prescriptions require prior authorizations through CVS/Caremark. The Fund does permit a one (1) time prescription fill only at a retail pharmacy, and after that you *must* use the CVS/Caremark Specialty Pharmacy mail order process. The CVS/Caremark Specialty Pharmacy contact number is 1-800-237-2767. You may contact CVS/Caremark for a list of prescriptions covered under the CVS/Caremark Specialty Pharmacy and CarePlus pharmacy.

Generic Equivalents And Brand Name Medications

Almost all prescription drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness.

When you receive a brand name medication, you generally pay more because they are more expensive. When you or your eligible dependent needs a prescription, you may want to ask your doctor whether a generic medication can be substituted for a brand name medication.

In general, using generic medications will help control the cost of health care while providing quality medications—and can be a significant source of savings for you and the Plan. Your doctor or pharmacist can assist you in substituting generic medications when appropriate.

When you need to order medication through the mail-order program, you should...

Step 1: Ask your physician to prescribe a 90-day supply of medication with refills.

Step 2: Mail the original prescription along with a completed order form/envelope to the mail-order program. You can obtain an order form/envelope from the Fund Office or CVS/Caremark.

Step 3: Allow about 14 days from the time you mail in your order to receive your prescription(s).

Note: If you need to begin taking the medication right away, you may want to ask your physician for two prescriptions:

- **A short-term supply which you can have filled right away at a participating retail pharmacy; and**
- **A 90-day refillable supply that you can have filled through the mail-order program.**

EXAMPLE

Lisa takes a medication that costs \$100 for a brand name form and \$50 for a generic equivalent. At the retail pharmacy, Lisa would pay \$30 for the brand name medication or \$15 for the generic equivalent. By choosing the generic equivalent, Lisa saves \$15 or 60%.

CVS/Caremark Generic Step Therapy

Program Under this program certain prescriptions **will require** you to first fill a generic prescription *before* utilizing a non-preferred brand prescription (which generally has a higher cost). The prescriptions which require use of this program fall into twelve broad categories (drug classes) as follows:

- Urinary antispasmodics
- HMG (CoA Reductase Inhibitors-Lipid lowering agents)
- ACE Inhibitors - ARB (Angiotensin II blockers)
- Nasal steroids
- Bisphosphonates
- Sleep aids
- Cox-2 inhibitors (Non-steroidal anti-inflammatory drugs)
- Triptans
- SABA (Short Acting Beta Agonists)
- NSA (Non-sedating Antihistamines)
- SRRI (Selective Serotonin Reuptake Inhibitors)
- PPI (Proton Pump Inhibitors)

If you do not fill the prescription with a generic drug, you will have to pay a higher copayment **and** the difference between the Plan's discounted cost of the drug and the actual cost of the drug. For example, if you have a prescription filled for a targeted brand medication under one of the drug classes listed above (assuming for the purposes of this example the cost to the Plan for this medication is \$200) without having tried a generic alternative first or without getting prior authorization for the target brand you will be responsible for the full \$200 cost at the pharmacy. If you have the script filled with a generic alternative in place of the targeted brand you would only be responsible for your generic copay. You may contact the Fund Office or CVS/Caremark with questions regarding this program.

If you have access to the Internet, you can access CVS/Caremark by going to **www.caremark.com**. On this Web site you can do a number of things, such as: printing a temporary ID card, ordering and managing your mail order drugs, obtaining a current formulary list, ordering forms, performing price comparisons for prescription drugs you are taking, obtaining copayment information and more.

Covered Prescription Drug Expenses

The Plan covers certain medications that require a written prescription from a physician or dentist. A licensed pharmacist must dispense these prescriptions. The Plan covers:

- Federal legend prescription drugs;
- Drugs requiring a prescription under the applicable state law;
- Insulin;

- Insulin syringes, test strips, and lancets;
- Oral contraceptives and contraceptive patches; provided that “Plan B” is covered only when a written prescription is required and obtained by a female eligible individual;
- Antibiotics;
- Prenatal vitamins;
- Smoking cessation prescription drugs, including Zyban;
- Intrauterine devices (but not for eligible children); and
- Fluoride tablets and drops under limited conditions.

The following medications are also covered under limited conditions, provided their uses have been pre-authorized through the Fund or CVS/Caremark with a written prescription as medically necessary (subject to other applicable Plan rules and FDA standards):

- Growth hormones;
- Vitamins;
- Imitrex;
- Rogaine;
- Retin-A, Differin and Renova for acne use only (authorization required for individuals over age 26);

- All injectable prescriptions, including those used for contraception;
- Dexedrine;
- Rebetrone;
- Viagra, Cialis, Levitra and similar drugs (only for a male Active Member, or the Spouse of a female Active Member) to a maximum of six (6) total pills per month. Such individual must submit appropriate documentation that sexual dysfunction is the result of or related to: diabetes, vascular disease, prostate injuries (prostate resections, radiation, cryo), spinal cord injuries, and/or medication-induced dysfunction where changing medications is not a viable alternative. The individual may be required to submit additional proof at least once every 12 months. Also, there is a *special exception* for those who have had a radical prostatectomy. In connection with the treatment of such procedure, provided your physician submits appropriate documentation to the Fund which is approved, the maximum would increase to fifteen (15) total pills per month for up to nine (9) consecutive months;
- Prescription drugs to treat renal failure, including Procrit; and
- Weight loss or control medications, including Merida and Xenical, provided you follow any applicable procedures of the Fund and CVS/ Caremark.

Prescription Drug Expenses Not Covered

In addition to the “Exclusions” on page 77, the following expenses are not covered under the Plan’s prescription drug benefits.

- Drugs that are not federal legend prescription drugs;
- Drugs which are sold over-the-counter, known as “OTC” drugs;
- Therapeutic devices or appliances, support garments, and other non-medical apparatus;
- Drugs intended for use in a physician’s office or another setting other than home use;
- Any drug that is experimental in nature, including compounded medications for non-FDA approved use;
- Prescriptions that you or your eligible dependents are entitled to receive without charge under any workers’ compensation law, or any municipal, state, or federal program;
- Any prescription that is not medically necessary;
- Birth control devices, including but not limited to RU486, other than oral contraceptives and contraceptive patches, contraceptive injections, diaphragms and IUDs which are covered as specifically stated in this booklet;
- Cosmetics;
- Drugs dispensed by an individual who is not a pharmacist or otherwise licensed to dispense drugs;
- Drugs that may be purchased without a prescription;
- Fertility medications, except for the coverage of Viagra, Cialis, Levitra and other similar drugs as described on page 61;
- Laetrile; and
- Smoking deterrents or weight control medications except as listed on page 61.

Dental

Preventive dental care can be important. To help you meet the cost of routine and unexpected dental care, the Fund provides dental benefits for you and your eligible dependents through the program administered by Delta Dental of New Jersey, Inc. (“Delta”).

FAST FACTS

- When you or your dependent needs dental care, you may choose any dentist in the Delta network.
- The Fund participates in two networks: Delta Premier and Delta PPO Plans.
- The amount you pay for coinsurance depends on the type of dental service you receive and whether it is in-network or out-of-network.



When you or an eligible dependent needs dental care, you can choose any dentist in the Delta network, which for our Fund is known as the “Delta Dental PPO plus Premier” network. The two networks this Fund participates in are called the **DELTA PREMIER** and **DELTA PPO PLANS**. At the time of your first appointment, *please* tell your dentist that you are covered under these Delta networks. Give him or her our group’s name and group number, as well as your unique Delta ID number. All of this information is on your Delta Identification card. Your eligible dependents also must provide your unique Delta ID number.

The Plan will pay covered expenses for the services of a dentist licensed to practice dentistry within accepted standards of dental practice as shown in the “Schedule of Benefits.” Dental benefits are included under COBRA continuation coverage, as described on page 32.

Coinsurance

The Plan pays a percentage of covered expenses, called coinsurance. The amount the Plan pays depends on the type of dental service you receive and whether it is incurred with an in-network Delta provider or whether it is incurred with an out-of-network provider. With respect to in-network claims, you are not responsible for any amounts in excess of the negotiated fee. With respect to out of network claims, you may be responsible for amounts in excess of the reasonable and customary (MAC) amounts. The Plan will cover dental expenses each year up to the maximum amounts listed in the “Schedule of Benefits.”

Covered Dental Expenses

Dental benefits will only be paid for services performed by a dentist, provided that cleaning or scaling of teeth may be performed by a licensed dental hygienist, if supervised by a dentist. Orthodontic and TMJ services are also paid under this benefit. The Plan covers the following dental services and supplies, up to the negotiated fee or reasonable and customary expenses when provided by a dentist.

Preventive Services

- Dental examinations, including scaling and cleaning of teeth or gums, up to twice per Plan year;
- X-rays, full mouth, or bitewing;
- Topical fluoride applications; and
- Space maintainers used in place of prematurely lost teeth.

Restorative Services

- Fillings to diseased or broken teeth;
- Extraction of teeth;
- Oral surgery, including the excision of impacted teeth;
- Endodontic treatment, including root canal therapy;
- Anesthesia in connection with any restorative service;
- Injection of antibiotic drugs in connection with a covered dental procedure;

- Treatment of periodontal and other diseases of the gums and tissues of the mouth;
- Crowns, inlays, and fillings;
- Repairing, recementing or relining of dentures, crowns, inlays, or bridgework;
- Installation of either removable denture (including adjustments within six months of installation) or fixed bridgework. The denture or bridgework must replace natural teeth that were lost while you or your eligible dependent were covered under the active Plan; and
- Replacement, or the addition of teeth, to a removable denture or fixed bridgework, provided that:
 - The replacement or addition of teeth is due to the loss of teeth that occurred while you or your eligible dependent were covered under the active Plan;
 - The denture or bridgework being replaced, or to which teeth are being added, has been in use at least five years and cannot be made serviceable; or
 - The denture being replaced is an immediate temporary denture installed with the past 12 months and is now being replaced by a permanent denture.

Other Services

Temporomandibular Joint Dysfunction (TMJ)

The Plan will pay covered charges for diagnosis, consultation, and treatment by a dentist or physician of TMJ for you or your eligible dependents up to the amounts listed in the “Schedule of Benefits.”

Charges for x-rays taken for a TMJ diagnosis are payable under this benefit only and are not payable under any other Plan benefit, including the x-ray and laboratory benefit. The benefits under this section will not exceed those listed in the “Schedule of Benefits.”

TMJ benefits are not payable for:

- An office visit charge on the same day an appliance is inserted; or
- Any other dental services performed on the day an appliance is inserted.

Benefits for the treatment of TMJ will not be provided under any other Plan benefit.

Orthodontic Benefit

The Plan will pay covered charges after the insertion of bands, for orthodontic treatment given by a dentist related to orthodontic services provided to you or your eligible dependents up to the amount listed in the “Schedule of Benefits.” Orthodontic benefits will not be paid for preliminary workup, diagnosis, or treatment of TMJ.

Orthodontic benefits are separate from and not included in the dental care benefits.

The period for filing a claim for orthodontic services begins when the bands are inserted. See page 80 for more details on filing dental claims.

Dental Expenses Not Covered

You should be aware that some expenses are not covered by the Plan. In addition to any “Exclusions” (see page 77), the Plan does not cover dental services that are not considered Medically Necessary by the Plan. The fact that a dentist may prescribe, order, recommend, or approve a service does not, of itself, make it Medically Necessary or make the charge a covered expense, even though the service is not specifically listed as an exclusion. The Plan is the final authority for determining whether services are Medically Necessary.



Vision

Vision coverage provides you and your eligible dependents with coverage for routine vision care expenses. The Plan provides coverage under two vision plan options: the Davis Vision Plan or the Indemnity Vision Plan. You have the option to decide which of these Plans to use.

FAST FACTS

- You may choose to be covered by Davis Vision or Indemnity Vision under the Plan.
- Your benefits include an eye exam and glasses or contacts every 24 months.



Vision services must be provided by, and supplies received from, an optician, optometrist, or ophthalmologist acting within the usual scope of his or her practice to be considered covered expenses under this benefit.

Covered Vision Benefits

If you receive benefits from either the Davis Vision Plan or the Fund's Indemnity Vision Plan, the benefit allowance IS ONCE EVERY OTHER PLAN YEAR. As a simple example, if you receive benefits under the Davis Vision Plan on August 1, 2012, you will next be eligible to receive Vision Benefits under the Plan on January 1, 2014 (assuming you still have Fund coverage at such time). However, eligible children **under age 13** as of the first day of the Plan Year, (i.e. January 1st), may receive vision benefits once in that Plan Year (assuming they also have Fund coverage at such time). The Plan will provide benefits for the following eligible expenses when prescribed by a doctor:

- Eye examinations;
- Lenses;
- Contact lenses; and
- Frames.

Please note that the Plan will not provide benefits in excess of those listed in the "Schedule of Benefits." Vision benefits covered under the Plan's medical benefit are not covered under the vision benefit.

Indemnity Vision Plan

If you use Indemnity plan coverage, you may visit any provider you wish. Under the Indemnity Vision Plan, benefits will be paid up to the amounts in the "Schedule of Benefits." After you or an eligible dependent have an eye examination, you or your dependent must obtain any associated materials (for example, eyeglasses or contacts) within 90 days. Benefits will not be paid after 90 days, subject to a very limited exception for those who have eye surgery after an eye exam.

The following expenses are not covered under the Indemnity vision plan:

- Replacement of broken, lost, or stolen lenses and/or frames;
- Duplicate glasses; and
- Expenses covered by a Contributing Employer or an insurance company.

When you need vision care...

- **Schedule an appointment with the optician, optometrist, or ophthalmologist of your choice or with a provider in the Davis Vision Network.**
- **Contact the Fund Office if you have questions.**

Davis Vision Plan

Davis Vision has a substantial network of private practice optometrists and ophthalmologists nationwide. When you visit Davis Vision network doctors, you receive discounted eye care services. For a free list of network providers, see Contact Information on page 5. Benefits will be paid up to the amounts in the “Schedule of Benefits.” The Davis Vision Plan is not available to Spouses or eligible dependents who are covered under another vision plan that is the primary payer.

Subject to the rules above, after you or your eligible dependent have an eye examination with a Davis Vision network doctor, you or your dependent must obtain any associated materials (for example, eyeglasses or contacts) within 90 days. Benefits will not be paid after 90 days, subject to a very limited exception for those who have eye surgery after an eye exam. Eyeglasses covered under the Davis Vision Plan must be selected from the Davis Vision Plan eyeglass collection.

In lieu of eyeglasses, you may select from the Davis Vision collection of Contact Lenses.

An Active Member is eligible for a second pair of glasses. The second pair of glasses may be clear prescription glasses, prescription sunglasses, or bifocal sunglasses. If your prescription is for bifocals, in lieu of a second pair of bifocals, you may select two pairs of eyeglasses for a maximum of three pair. You may not elect more than one pair of sunglasses, premier frames, or photo-grey extra lenses. This benefit is allowed ***once every other Plan Year.***

Your Spouse may receive two pairs of glasses in lieu of bifocals otherwise, one pair (of non-bifocal glasses) is allowed ***once every other Plan Year.*** Your Spouse may elect only one pair of premier frames or photo-grey extra lenses or one pair of progressive lenses.

Eligible children ***under*** age 13 as of the first day of the Plan Year (i.e., January 1st) may obtain one pair of glasses ***once every 12 months.*** Age is determined on the first day of the Plan year, so as an example if a child is age 13 on January 1, 2012, then that child is considered to be 13 for the entire 2012 year. Eligible children age 13 or ***older*** can obtain one pair of glasses ***every other*** Plan Year.

Optional frames, lens types and coatings are available for additional copayments which you would be responsible for. For more information, please contact Davis at 1-800-999-5431.

Prescription Safety Glasses (Active Members only)

If you need prescription safety glasses to prevent work-related eye injuries, benefits are payable for an eye exam, and a pair of safety frames and lenses once every other Plan Year when you visit a Davis Vision provider. There are no out-of-network provisions with regard to the safety eyewear.

Vision Services Not Covered

In addition to the “Exclusions” on page 77, the following expenses are not covered under the Plan’s vision benefit:

- Special procedures, such as orthoptics or functional vision training, and special supplies, such as non-prescription sunglasses or subnormal vision aids;
- Examinations in excess of the limitations listed on page 67;
- Lenses available without a prescription;
- Anti-reflective coatings or charges for tinting and charges for sunglasses or light-sensitive glasses in excess of the amount that would be a covered charge for non-tinted glasses except for you or a Spouse as described under the Davis Vision Plan;
- Eye examinations required by an employer as a condition of employment that the employer is required to provide under a Collective Bargaining Agreement, or those required by a governmental agency;
- Charges for lenses and frames that are provided before the date you become eligible under the Plan;
- Ancillary services, whether performed by an optometrist or ophthalmologist;
- Reflective eye surgery, including but not limited to, radial keratotomy, and lasik corrective vision surgery;
- Items not covered under the Plan’s general exclusions starting on page 77; and
- Replacement of lost or damaged contact lenses.



Disability/Death

Weekly Disability, Death and Accidental Death and Dismemberment (AD&D) benefits help provide financial protection to you and/or your family in the event you become injured or die.

FAST FACTS

- If eligible, your designated beneficiary will receive a lump sum benefit if you die while you are an active member covered by this Fund.
- Your beneficiary must provide the Fund Office with a certified copy of your death certificate in order to receive a benefit.
- If you become disabled and cannot work, you may be eligible for Weekly Disability Benefits.



Weekly Disability Benefits (Active Members Only)

Eligibility

If you become disabled, you may be eligible for Weekly Disability benefits if you:

- Are unable to perform the regular duties of your occupation due to the illness or injury;
- Have an illness or injury that did not occur or resulted while working in Non-Covered Employment;
- Are under the care of a physician during the period of your disability;
- Have your physician state on the Fund claim form the dates of disability and the diagnosis;
- Are either: (i) eligible for benefits under this Plan at the time your injury or illness occurs, or (ii) become eligible for benefits under this Plan while still disabled due to a prior injury or illness; and
- Are not employed by anyone, including engaging in Non-Covered Employment, during the period of your disability.

Employees of the Union or the Fund are not eligible for Weekly Disability benefits. Also, eligibility for Weekly Disability benefits will end when you lose your coverage as a Member, including due to your retirement. In addition, Weekly Disability benefits **are not** available under (1) COBRA continuation coverage or (2) either Retiree Plan.

Benefits

The amount of Weekly Disability benefits is listed in the “Schedule of Benefits” on page 15. Benefits are payable for up to 26 weeks and are taxable to the recipient. These benefits are paid once every two weeks.

If you cannot work because of a non-work related injury or sickness:

- **Call your employer and the Fund Office.**
- **See a physician as soon as possible.**
- **File a claim with the Fund Office.**

When Benefits Begin

For most Members, your Weekly Disability benefits for a non-occupational disability will begin the first day of your disability if caused by an injury. Benefits begin on the eighth day of your disability due to an illness. If you have an illness, you must be unable to work for eight consecutive days or longer for benefits to be payable. For an individual who is not covered under the Plan at the time the disabling injury or illness occurs, but who later becomes a Member, he or she will be eligible as of the date he or she becomes a Member in situations involving injury, and for illnesses, the date he or she becomes a Member or, if later, eight days following the onset of the illness.

In situations where a Member is paid by an Employer for sick and/or vacation during the disability period, Weekly Disability benefits from the Fund will start after the Employer’s payment has ended. The duration of the sick and/or vacation time will count against the Fund’s 26 week maximum Weekly Disability benefit period. If Weekly Disability benefits are paid to you due to an injury that requires surgery on a specific

body part and a second surgery is required on the same body part for the same medical condition, any further benefits that are paid as the result of the second surgery will be considered as an injury not an illness.

You must provide evidence of your continuing disability to the Fund Office. Your physician must provide updated reports and/or other medical proof of your disability at the request of the Trustees.

Maximum Benefits

Subject to the other limits in this section, Weekly Disability benefits will be paid for one period of disability for up to 26 weeks. Two or more periods of total disability will be considered as one period of disability unless:

- You return to full-time work (40 or more hours per week) in Covered Employment for at least two consecutive calendar weeks between the two periods of disability; or
- The subsequent period of disability is due to an injury or illness entirely unrelated to the causes of the previous disability and the subsequent period begins after you return to active work in Covered Employment full-time for at least one day (eight hours).

Other Exclusions for Weekly Disability Benefits

If you are receiving or are entitled to receive unemployment compensation or compensation under a salary continuation plan from your employer (including Supplemental Unemployment Benefits through this Plan, workers' compensation benefits, or work-loss provisions of an insurance arrangement), Weekly Disability benefits are not payable. Also, as noted earlier, Weekly Disability benefits *are not*

available under COBRA continuation coverage or either Retiree Plan.

Death Benefits (Active Members Only)

Death benefits are paid if you die while eligible for benefits under the Plan for any cause, other than work in Non-Covered Employment. Please note that Death benefits *are not* available under COBRA continuation coverage.

The spouse or beneficiary must notify the Fund immediately upon the death of the member. The proper paperwork will be sent to the spouse or beneficiary, including a death benefit (life insurance) application. The Fund must receive all required documentation (e.g., application, certified copy of the death certificate, etc.) before the Death benefit can be paid.

Benefit Amount

The amount of the benefit is shown in the "Schedule of Benefits" on page 15. Benefits are *generally* paid in one lump sum. At the present time, the Fund's death benefit is paid through Reliance Standard Insurance Company (Reliance).

To designate a beneficiary, request a beneficiary form from the Fund Office. Be sure to review your beneficiary designation from time to time to ensure your Death benefits are paid as you wish.

Conversion Right for Actives Who Lose Coverage

An Active Member can lose coverage under the Plan for a reason other than death. When such coverage is lost, the Member's life insurance

through the Fund **will terminate**, except that he or she can convert the group life insurance policy he or she was covered under (namely, the Fund's group policy with Reliance) into an **individual policy**. The ability to do this is called a "conversion right."

If a former Member wishes to take advantage of this conversion right, he or she must notify Reliance in writing within 31 days of the date Fund coverage was lost. If the conversion right is properly elected, it is the responsibility of the former Member to pay the full cost of the life insurance coverage directly to Reliance in a timely manner. Reliance has informed us that no proof of good health is required, and they will determine the applicable premium amount.

Reliance also noted that a former Member should write to the address listed below within the 31-day deadline, state that he or she wishes to exercise the conversion right, and reference Group Policy Number: **GL 147869**; Policyholder: International Union of Operating Engineers Local No. 478 Health Benefits Plan.

Contact Reliance at:

Reliance Standard Life Insurance Company
2001 Market Street, Suite 1500
Philadelphia, PA 19103
Telephone number: 1-800-351-7500

PLEASE KEEP THESE ITEMS IN MIND:

- ***The Fund's Death benefit, along with the conversion right described above, is not available under COBRA continuation coverage.***

- The **only time** a former Member can elect the conversion right, by notifying Reliance, is within 31 days from his or her loss of Fund coverage.
- This is the only notice you will receive about the conversion right, and the Fund has no obligation to give you any further notice of the conversion right.

Accidental Death and Dismemberment (AD&D) Benefit (Active Members Only)

The Accidental Death and Dismemberment (AD&D) benefit is payable for the loss of life, the loss of limb(s), or the entire and irrecoverable loss of sight of one or both eyes. Benefits are payable only if the loss results from an accident while you are eligible. As a general rule, "accident" means an unplanned, unforeseen, and unexpected event or happening causing injury or death (not including the exclusions below). The loss must occur within 90 days of the accident.

The AD&D benefit is **not** available under COBRA continuation coverage. At the present time, the Fund's AD&D benefit is also paid through Reliance Standard Insurance Company (Reliance).

Benefit Amount

If you suffer any combination of losses as shown below as the result of one accident, only one amount (the largest) is payable for all losses. The amount payable for all losses resulting from one accident will not exceed the principal amount listed in the "Schedule of Benefits" on page 14. Benefits are payable for the following losses: Loss of limb means dismemberment by severance at or above the wrist or ankle joint. Partial loss of

one limb means dismemberment by severance of three or more digits of a hand or foot. Loss of sight means the entire and irrecoverable loss of sight.

Benefits are paid directly to you for an injury or to your beneficiary in the event of your death. The AD&D benefit is in addition to the Death benefit.

Type Of Loss	Benefit
Life	Full amount, paid to your beneficiary
Loss of two limbs, sight of both eyes, or of one limb and sight of one eye	Full amount, paid to you
Loss of one limb or sight in one eye	One half of the full amount, paid to you
Partial loss of one limb	One quarter of the full amount, paid to you

Limitations and Exclusions

The following losses are not covered under the AD&D benefit:

- Bodily or mental illness or disease of any kind;
- Hernia, ptomaine or bacterial infections (unless occurring as a result of accidental ingestion or infections caused by accidental injury);
- Suicide, attempted suicide, or intentionally self-inflicted injury;
- Injury sustained outside of the United States or Canada;
- Travel or flight in an aircraft, except while traveling as a passenger on a licensed passenger aircraft of a carrier approved by the U.S. government flying a normal route;
- Participation in the commission of a felony;
- War or any act of war, including service in the armed forces of any country while the country is engaged in war or on police duty as a member of any military, naval, or air organization;
- Injury sustained while legally intoxicated due to consumption of alcohol, while under the influence of any controlled substance not prescribed by a physician, or while under the influence of a controlled substance prescribed by a physician where you have not followed the terms of the prescription; or
- Injury sustained in Non-Covered Employment.

Naming a Beneficiary

A beneficiary is the person or persons shown in the Plan's records that you designate to receive your Death and AD&D benefits.

You may designate anyone you wish as your beneficiary for Death (Life Insurance) and AD&D benefits. To change or designate a beneficiary(ies), you need to file a form with the Fund Office. You can change your beneficiary at any time, without the consent of your previous beneficiary.

On the beneficiary form, be sure to list your beneficiary's full name, address, his or her Social Security number and his/her relationship to you. The change will take effect when the Fund Office receives the signed form, and the form on file with the Fund Office at the time of your death will control. Your beneficiary designation will be kept on file with the Fund Office. It is very important that you designate a beneficiary.

If you have named more than one beneficiary, but have not specified a certain percentage to be paid, the benefit will be divided equally. If you have not named a beneficiary, or if there is no surviving beneficiary at the time of your death, payment will be made to the first of the following:

- Your surviving Spouse;
- Your surviving child(ren);
- Your surviving parents, in equal shares;
- Your surviving brothers and sisters, in equal shares; or
- Your estate.

If your beneficiary is a minor or in the opinion of the Trustees is legally incapacitated, the Trustees reserve the right to make payment of any benefit pursuant to the requirements of state law governing payments to minors and/or incapacitated individuals.



Exclusions



The following list of exclusions applies to all expenses, unless an exception is stated, and applies to all benefits provided under the Plan. In addition to the exclusions listed under each benefit section, no benefits are payable under the Plan for any of the following exclusions:

- Charges in excess of those that are considered reasonable and customary (MAC) or for any medical procedures, treatments, devices, drugs, or other medical services that are not medically necessary.
- Employment-related injuries or illnesses covered by a workers' compensation act or similar legislation, except:
 - As otherwise payable under Death or AD&D benefits;
 - That the Plan will consider charges of eligible dependents who are not self-employed in Connecticut, elect not to be covered with respect to self-employment by the Connecticut Workers' Compensation law, and do not earn more than \$5,000 from self-employment in the calendar in which the medical charges occurred;
 - That the Plan will consider your charges that are related to a specific employment-related injury or illness, provided you brought a claim for benefits for the illness or injury under a workers' compensation act or similar legislation and the claim was resolved by settlement, judgment, stipulation, award or otherwise, before your initial eligibility date under the Plan.
- Hospital, medical or surgical treatment or other treatments provided or paid for by the states, U.S. government, or any instrumentality, except as provided by law.
- Injuries or illnesses caused by war or any act of war, declared or undeclared.
- Injuries or illnesses incurred while on active duty in any branch of the armed services of any country.
- Charges for Experimental Procedures.
- Charges for routine physical examinations, except those that are covered under the Plan.
- Charges payable by another source as the result of the Plan's coordination of benefits (COB) provisions. This includes charges that would have been payable by a payer primary to this Plan, but for you or your eligible dependent's failure to follow rules and restrictions of the primary payer.
- Charges payable by a third party, except as permitted under the Plan.
- Charges for services that do not conform to accepted standards of medical or psychiatric practice and charges for services in excess of those normally required for treatment or prevention of illness or injury.
- Charges for services beyond the scope of the license of the person performing them.
- Charges for cosmetic surgery or treatment, except those specifically covered under the Plan.

- Charges for the care of the feet in a hospital unless the condition of the feet was the reason for the hospitalization, or outside a hospital when it relates to treatment of week, strained, or flat fee or of any metatarsalgia or bunion (except for charges for an open-cutting operation).
- Charges for treatment (including cutting or removal) of corns, calluses, or toenails (but not excluding charges for partial or complete removal of nail roots) except in connection with treatment of a metabolic disease, such as diabetes or peripheral vascular disease, such as arteriosclerosis.
- Services rendered by a physician for which you or your eligible dependents incur a legally-enforceable charge, and services rendered for an appliance received in a hospital, medical, dental, or podiatric department or clinic maintained by or on the premises of the Fund, or the employer, or labor union.
- Hormone injections, or the injection of any other substances, unless it is ordered by a physician in connection with the treatment of a particular disease.
- Examination of the eyes for eyeglasses, except as covered under the vision benefit.
- Outpatient medications and drugs, except as covered under the prescription drug benefit.
- Private duty nursing for a nurse rendered while hospitalized.
- Charges for ancillary vision services (e.g., visual training or orthoptics) provided the fundus photography is covered only where there is diagnosis of retinal pathology.
- Claims for medical benefits received by the Fund Office more than two years after the date services are rendered.
- Claims for Death, AD&D, or Weekly Disability benefits received by the Fund Office more than two years after the date of the injury, illness, or other occurrence that brought rise to the claim.
- Charges for injuries or illness incurred while engaged in Non-Covered Employment.
- Charges for complications in connection with a non-covered service.
- Charges for surgical or medical abortion other than:
 - Medical complications that arise for a Member or the Member’s Spouse;
 - When the mother (a Member or the Member’s Spouse) would be endangered if the fetus were carried to term; or
 - Spontaneous non-elective abortion incurred by a Member or a Member’s Spouse.
- Charges related to abortion, pregnancy, or infertility treatment or procedures of an eligible child, except those described in the Pregnancy Benefit on pages 47-48.

Claims and Appeals



All claims should be filed within two years of the date services are received or the claim is incurred, or your claim will be denied.

If you or an Eligible Dependent has coverage under more than one health care plan, benefits are coordinated (see page 87).

How to File Claims and Appeals

Medical Claims

When you receive medical treatment in Connecticut, you must present your Anthem BlueCross BlueShield identification (ID) card at the time of your visit. Both in-network and out-of-network medical providers submit their claims directly to Anthem BlueCross BlueShield of Connecticut. Benefits will then be paid directly to the doctor or hospital providing the services. Your BlueCross BlueShield ID card provides the group and identification numbers the provider will need to submit your claim. While it is preferred that all claims be submitted electronically to Anthem BlueCross BlueShield, paper claims may be mailed to:

**Anthem Blue Cross Blue Shield
National Account Division
P.O. Box 533
North Haven, CT 06473**

If a paper claim must be submitted, be sure to attach an itemized statement that includes:

- **Patient name;**
- **Date of service;**
- **Itemized expenses;**
- **Procedure codes;**
- **Diagnosis;**
- **Provider's name, address, phone number, and tax I.D. number.**

Claims incurred outside of Connecticut, regardless of whether they are incurred with an in-network or out-of-network provider, should be submitted to the local Blue Cross plan of that respective area. Your claim should reference group number **000ELH834** and your individual Anthem BCBS identification number.

If you visit an out-of-network provider, you should present your Anthem BlueCross BlueShield identification (ID) card. If your provider won't bill Anthem BCBS, then you can submit the out-of-network paper medical claims to:

**International Union of Operating Engineers
Local No. 478 Health Benefits Plan
1965 Dixwell Avenue
Hamden, CT 06514-2400**

In all situations, medical claims must be properly filed within two (2) years of the date services are received or they will be denied.

Dental Benefits

You should present your Delta Dental card when receiving dental, orthodontic or TMJ treatment, regardless of whether such treatment was incurred with an in-network or with an out-of-network provider. All such claims are to be sent to:

Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, NJ 07054

If a claim is denied or reduced, you may file an appeal with Delta Dental to have your claim reconsidered.

Your claim should reference **group number 4634** and your individual Delta ID number.

Dental claims must be properly filed within two (2) years of the date services are received or they will be denied.

Prescription Drug, Vision, Weekly Disability, Death and AD&D Claims

If you incur a prescription drug claim from a pharmacist who is not part of the CVS/Caremark network, or you wish to obtain Weekly Disability, Life, or AD&D benefits, you should call the Fund Office.

If you need to file an AD&D claim (Accidental Death and/or Dismemberment), or your beneficiary needs to file a Death and/or AD&D benefit claim, you, or your beneficiary should contact the Fund Office and notify the Fund of the death and/or accident. The Fund has the appropriate paper work to send to you or your beneficiary advising what documents will need to be submitted. Written proof of your dismemberment or death will need to be

provided to the Fund Office before benefits are paid. Dismemberment proof must be provided within 90 days of your loss. As noted on page 73, the Fund's Death and AD&D benefits are provided through an insurance company (Reliance), so while we work as quickly as we can, Reliance ultimately issues the benefit check(s). Any Death and/or AD&D benefit claim must be properly filed within two years of the death or accident, as applicable, or the claim will be denied.

Send claims for prescription and vision (if incurred with out-of-network providers), Weekly Disability benefit, Death, Accidental Death and Dismemberment claims to:

International Union of Operating Engineers
Local No. 478 Health Benefits Plan
1965 Dixwell Avenue
Hamden, CT 06514-2400

Claims and Appeal Procedures

In this section, the term "Fund Office" means the office or organization designated by the Trustees for handling claims. A "claimant" is an individual claiming a benefit under the Plan.

Claim Filing Procedures

In order for the Plan to pay benefits, a claim must be filed with the Fund office, depending on the type of claim, in accordance with the procedures described in this section. A claim can be filed by an Active Member, or eligible dependent or by someone authorized to act on behalf of the member or eligible dependent. Please remember:

1. For purposes of our Plan, a claim is considered to be filed on the date it is received at the correct Fund Office or PPO network address AND all other required information has been

submitted along with such claim. If a claim contains incomplete or incorrect information, it will be denied.

IMPORTANT – CLAIMS DENIED FOR DETAILS OF INJURY:

In connection with the rule above, the Fund will deny any claim that appears to be due to an accidental cause (for example, a broken leg or back injury), unless the claim is accompanied by a full *explanation as to how the injury occurred*. In such instances, the Explanation of Benefits statement provided to the Participant will include a note that he or she must provide the Fund Office with an explanation of the event that led to the injury. This information is **REQUIRED** in writing in order for the Fund to determine if there is another party who is responsible for payment, such as the claimant's employer or insurance carrier in the event of a work-related accident, or the party who is at fault in a motor vehicle or motorcycle accident. In addition, you are **REQUIRED** to inform the Fund if you have filed a lawsuit to recover for any injuries you may have suffered due to an accident. Until the Fund Office receives appropriate information as described above, injury-related claims such as these will remain denied.

2. A "claim" is a request for Plan benefits, normally because the claimant has incurred a health care expense. A request for confirmation of Plan coverage is not a claim if the expense has not yet been incurred, unless the Plan requires prior approval as a condition of payment. A general inquiry about eligibility or coverage when no expense has been incurred

is not a claim, nor is presenting a prescription to a pharmacy. Also, a request to improve or expand Plan benefits is not a claim.

If you or an eligible dependent has coverage under more than one health care plan, benefits are coordinated (see page 87).

3. Unless otherwise noted in this booklet, claims must be properly filed within **two (2) years** of the date the applicable services were rendered.
4. A claimant may designate another person as his or her authorized representative for purposes of filing a claim. Except in the case of an urgent care claim, the designation must be in writing, unless the authorization states otherwise, all notices regarding the claim will be sent to the authorized representative and not to the claimant.

A routine assignment of benefits so that the Plan will pay the provider directly is not a designation of the provider as the authorized representative.

IMPORTANT NOTE

As you probably know, the Supplemental Unemployment Benefits Fund was merged into the Health Fund in late 2010. While claims for Supplemental Unemployment Benefits or "SUB" are now provided for by the Health Fund, we still refer to the SUB Fund's Summary Plan Description (printed in 2010) when dealing with any type of SUB eligibility, claim or appeal issue.

Claim Processing Time Periods

The amount of time the Plan can take to process a claim depends on the type of claim. A claim is one of the following categories:

- A “post-service” claim is a claim in which the claimant has already received the treatment or supply for which payment is now being requested. Most claims are post-service claims.
- A “disability claim” is a claim for Weekly Disability benefits.
- A “pre-service claim” is a request for preauthorization of a treatment or supply that requires approval in advance of obtaining the care.
- An “urgent care claim” is a pre-service claim where if normal time periods were applied for making non-urgent care determinations could seriously jeopardize the claimant’s life, health, or ability to regain maximum function, or that could subject the claimant to severe pain that cannot be adequately managed with the proposed treatment.
- A “concurrent care claim” is also a type of pre-service claim. A claim is a concurrent care claim if a request is made to extend a course of treatment beyond the period of time or number of treatments previously approved.

If all the information needed to process the claim is provided to the Fund Office, the claim will be processed as soon as possible. However, the processing time needed will not exceed the time frames allowed by law, which are:

- Post-service claims – 30 days;
- Disability claims – 45 days;

- Pre-service claims – 15 days;
- Urgent care claims – 72 hours;
- Death or AD&D claims – 90 days;
- Concurrent care claims – 24 hours if the concurrent care is urgent and if the request for the extension is made within 24 hours before the end of the already authorized treatment. If the concurrent care is not urgent, then the pre-service time limits apply.

When Additional Information Is Needed

If additional information is needed from the claimant, the doctor or the provider, the necessary information or material will be requested in writing. The request for additional information will be sent within the normal time limits shown above, except that the additional information needed to decide an urgent care claim would be requested within 24 hours.

It is the claimant’s responsibility to see that the requested information is provided to the Fund Office. In general, the normal processing period will be extended by the time it takes the claimant to provide the information, and the time period will start to run once the Fund Office has received a response to its request. However, if the claimant does not provide the requested information within 45 days (48 hours for an urgent care claim), the Fund Office will make a decision on the claim without it, and the claim could be denied as a result.

Plan Extension

The time periods above may be extended if the Fund Office determines that an extension is necessary due to matters beyond its control (but not including situations where it needs to request further information from the claimant or the provider as outlined above). The claimant will

be notified before the expiration of the normal approval/denial time period if an extension is needed. If an extension is needed, it will not last more than:

- Post-service claims – 15 days;
- Disability claims – 30 days (a second 30-day extension may be needed in special circumstances);
- Pre-service claims – 15 days;
- Death or AD&D claims – 90 days.

Claim Denials

If all or a part of the claim is denied after the Fund Office has received all other necessary information from the claimant, the claimant will be sent a written notice giving the claimant the specific reason(s) for the denial. The notice will include:

- Reference to the Plan provisions on which the denial was based;
- An explanation of the claim appeal procedure;
- If applicable, a description of any additional material or information necessary for the claimant to perfect the claim, and the reason such information is necessary;
- A description of the appeal procedures and the applicable time limits for following the procedures;
- A statement concerning the claimant's right to bring a civil action under Section 502(a) of ERISA;

- In cases where the Plan relied upon an internal rule, guideline, protocol, or similar criterion to make its decision, the notice will state that the specific internal rule, guideline, protocol, or criterion will be provided to the claimant free of charge upon request;
- If the decision was based on medical necessity or if the treatment was experimental, the notification will include either an explanation of the scientific or clinical judgment for the determination or a statement that the explanation will be provided free of charge upon request; and
- For urgent claims, a description of the Plan's expedited review process will be provided.

Claim Appeal Procedure

Appealing A Claim Denial

If a claim has been denied in whole or in part, the claimant may request a full and fair review (also called an "appeal"), by filing a written notice of appeal with the Plan. The claimant should submit the request for review to:

***International Union of Operating Engineers
Local No. 478 Health Benefits Plan
ATTN: Board of Trustees
1965 Dixwell Avenue
Hamden, CT 06514-2400***

When filing an appeal:

1. A notice of appeal must be received by the Fund Office not more than 180 days after the claimant receives the written notice of denial of the claim, provided that in connection with Death or AD&D claims, the applicable time period is 60 days. The appeal is considered to have been filed on the date the written notice of appeal is received by the Fund Office.

2. The claimant may orally request that the Plan review its denial of an urgent care claim by calling the Fund Office, or the claimant may also submit the request in writing.
3. For post-service claims and disability claims, the Review Committee will be the Board of Trustees or will be a committee of the Board of Trustees. For pre-service claims, the Review Committee will be a Plan fiduciary selected by the Board of Trustees. The Review committee will not include the person, or a subordinate of the person, who made the original claim denial.
4. Another person may represent the claimant in connection with an appeal. If another person claims to be representing the claimant in the claimant's appeal, the Trustees have the right to require that the claimant give the Plan a signed statement, advising the Trustees that the claimant has authorized that person to act on the claimant's behalf regarding the claimant's appeal. Any representation by another person will be at the claimant's own expense.
5. The claimant or his or her authorized representative may review pertinent documents and may submit comments and relevant information in writing.
6. Upon written request, the Fund Office will provide reasonable access to, and copies of, all documents, records or other information relevant to the claim. The Fund Office will not charge the claimant for copies of documents requested in connection with an appeal.
7. If the Fund Office obtained an opinion from a medical or vocational expert in connection with the claim, the Fund Office will, on written request, provide the claimant with the name of that expert.

8. In deciding the claimant's appeal, the Trustees will consider all comments and documents submitted, regardless of whether that information was available at the time of the original claim denial. The review will not defer to the initial denial, and will take into account all comments, documents, records and other information submitted by the claimant, without regard to whether such information was previously submitted or relied upon in the initial determination.
9. If an appeal involves a medical judgment, such as whether treatment is medically necessary, the Trustees will consult with a medical professional who is qualified to offer an opinion on the issue. If a medical professional was consulted in connection with the original claim denial, the Trustees will not consult with the same medical professional (or a subordinate of that person) for purposes of the appeal.

NOTE

It is the standard practice of the Fund to hold the name of a claimant in strict confidence during the appeal process (i.e., no name is disclosed to the decision-maker(s)) so that all claimants are treated with the same degree of fairness and impartiality.

Notification Following Review

If the appeal is for an urgent care claim, the claimant will be notified of the decision about the appeal as soon as possible, taking into account the circumstances, but not later than 72 hours after receipt of the request for review. In the case of non-urgent, pre-service claims, the claimant will be notified no later than 30 days after receipt of the request for review.

A review and determination for weekly disability and post-service claims will be made no later than the date of the meeting of the Trustees

that immediately follows the Plan's receipt of a request for review. However, if the request is filed within 30 days preceding the date of such meeting, a determination may be made by no later than the date of the second meeting.

If special circumstances (such as the need to hold a hearing) require a further extension of time, a determination will be made not later than the third meeting of the Trustees. Before the start of the extension, the claimant will be notified in writing of the extension, and that notice will include a description of the special circumstances and the date as of which the termination will be made.

The claimant will be informed of the Trustees' decision, normally within five calendar days of the review. The decision will be in writing unless the appeal was for an urgent care claim and the claimant is advised by telephone or fax. When the claimant receives the written decision, it will contain:

- The reasons for the decision and specific references to the particular Plan provisions upon which the decision was based;
- A statement explaining that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- In connection with any denial, a statement of the claimant's right to bring an action under Section 502(a) of ERISA;
- If applicable, the claimant will also be informed of his or her right to receive free of charge upon request, the specific internal rule, guideline, protocol or similar criterion relied on to make the decision; and

- If the decision was based on a medical judgment, the claimant will receive, an explanation of that determination or a statement that such explanation will be provided free of charge upon request.

Lawsuits and Limitations

You may not start a lawsuit against the Plan to obtain benefits until after you have exhausted all of the procedures described in this section and final decisions have been reached, or until the appropriate time frame has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be needed to reach a final decision.

The law also permits you to pursue your remedies under Section 502(a) of ERISA without exhausting these appeal procedures if the Fund has failed to follow them. No lawsuit to recover benefits under this Plan may be started more than one year and one hundred and twenty days (120) after the date of the Fund's decision on a claim denial, or an appeal of a claim denial, as applicable.

Because the Fund grants its fiduciaries discretionary authority to determine eligibility for benefits and to construe the terms of the Plan, the issue in any lawsuit will be limited to whether or not the Board of Trustees (or its delegates) acted arbitrarily or capriciously in making its determination.



Plan Facts



Coordination of Benefits

When members of a family are covered under more than one group benefits plan, there may be instances of duplication of coverage—two plans paying benefits for the same medical expenses. The Plan’s Coordination of Benefits (COB) provision coordinates the benefits payable by this Plan with similar benefits payable under other plans, excluding Weekly Disability, Death, and Accidental Death and Dismemberment (AD&D) benefits.

In this section:

- The term “plan” means any arrangement that provides benefits or services for medical, dental, or visual care or treatment, including but not limited to group, blanket, or franchise insurance coverage, group practice, or other prepayment coverage on an individual basis, or coverage under a labor-management plan, union welfare plan, employer organization plan, or employee benefit organization plan. The term “plan” also includes any arrangement providing benefits such as individual direct payment coverage, including, but not limited to benefits provided under any applicable automobile insurance law, medical care components of long-term care contracts and, to the extent permitted by law, Medicare and other federal benefits.
- Primary plan means the plan that determines its benefits based on its allowable expenses without reducing its benefits by those of another plan.

Under the COB provision, if you and/or your eligible dependent are covered by this Plan as well as by another plan, which provides group health benefits, benefits will be coordinated between the two plans. If you or any of your dependents are covered under any other group

plan, the total payment received for any one person from all programs combined may not be more than 100% of the “allowable expenses” (excluding Weekly Disability, Death, and Accidental Death and Dismemberment (AD&D) benefits). Allowable expenses are any necessary and reasonable expenses actually charged for medical services, treatment or supplies covered by one of the plans under which you or your dependent is covered, including covered expenses under this Plan. In determining allowable expenses, the Plan will also consider any PPO discounts or negotiated fees that apply.

The Plan can never pay more on any claim than it would if the COB provision did not exist.

Who Pays First

If you or your eligible dependents are covered by another plan(s), the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays full benefits first, then the other plan(s) pay(s). When both you and an eligible dependent are covered under different group health plans as covered employees, both you and your dependent should file the claim with your own plan. Make sure you both provide all requested information on the claim forms about your dependent’s employment. The Fund Office and the other Plan(s) will then decide the “primary” and “secondary” responsibility of the Plans (see below).

The primary plan is the plan that must pay benefits on the claim first. The secondary plan is the plan that makes payments after benefits have been provided by the primary plan. When your claims are coordinated, you may receive payments from the primary plan, but additional payments from the secondary plan (which may provide up to 100% payment for your claim). This Plan normally pays the secondary portion of

claims at 90%; allowed amounts will be limited to either the negotiated fee or the reasonable and customary amount (see the “Schedule of Benefits” for information on how certain benefits are coordinated). Deductibles do not apply to secondary claims.

If you or your eligible dependents have coverage under another plan(s), the following rules apply:

- If you or your dependent is covered by another group plan that does not have a COB provision, the other plan will always pay first.
- If a person is a covered employee under one plan and a dependent under another plan, the plan covering the person as an employee will pay first, and the plan covering the person as a dependent will pay second.
- If a plan covers a person as an active employee or as a dependent, that plan will pay first, and any other plan covering the person as a retiree will pay second.
- If a person works for two employers, the plan that has covered the person for a longer period of time will pay first and the other plan will pay second.
- The following rules apply with respect to eligible children who are covered by one or more plan(s) of their parents, unless the terms of a court order, including a QMCSO (see page 23) provide otherwise:

– For an eligible child whose parents are married or living together (regardless of marital status), the plan of the parent whose birthday is earlier in the calendar year (regardless of year of birth) will pay first, and if both parents have the same birthday, the

plan that has covered the particular parent the longest will pay first (this is the “birthday rule”);

– For an eligible child whose parents are divorced or separated, or not living together (regardless of marital status), these rules apply:

- * If a court order states that a parent is responsible for providing health care coverage for the child, and the plan is aware of the order, that plan is primary. If the parent with responsibility has no health care coverage, but that parent’s spouse does, that parent’s spouse’s plan pays first.
- * If a court order says both parents are responsible for providing health care coverage for the child, or the court order provides for joint custody without specifying which parent has responsibility, the birthday rule applies.
- * If there is no court order, then the following order of responsibility applies: (1) the plan of the custodial parent, (2) the plan of the custodial parent’s spouse, (3) the plan covering the non-custodial parent, and (4) the plan covering the non-custodial parent’s spouse.

When a plan refuses or fails to pay first because a person has not complied with the terms of the Plan, this Plan will consider 20% of the charges submitted for payment.

Coordination of Benefits With Medicare

The Fund will pay benefits without regard to Medicare for:

- Active employees and their dependents age 65 or older or who are entitled to Medicare benefits because of their age; or
- Active employees and their dependents under age 65 who are entitled to Medicare benefits due to any disability *other than* End Stage Renal Disease.

Any *other* person who is covered under the Plan and who is eligible for Medicare, including surviving or divorced spouses and persons entitled to Medicare due to End Stage Renal Disease (after the 31st month of Medicare coverage) will have their medical benefits coordinated with the total amount of benefits paid by Medicare (or those benefits that would have been paid by Medicare if that person has enrolled).

Persons age 65 and older or disabled are eligible to enroll for benefits under Title XVIII of the Social Security Act of 1965 (Medicare). Part A of Medicare, which covers hospital expenses, generally does not require a premium payment. Part B covers other types of medical expenses and requires you to pay a monthly premium. In order to be covered under Parts A and B, you need to apply.

When coordinating with Medicare, this Plan and Medicare together will not cover more than 100% of covered expenses for an accident or illness.

If, while you are actively employed, you or any of your eligible dependents become entitled to

Medicare because of End Stage Renal Disease (ESRD), this Plan pays first and Medicare pays second for 30 months, starting the earlier of the month in which Medicare ESRD coverage begins or the first month in which the individual receives a kidney transplant. After the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

With respect to Medicare Part D (prescription drug coverage), we want you to know that the Fund's prescription drug coverage is "creditable." In plain terms, that means that our Fund's prescription drug program is expected to pay out at least as much as the standard Medicare Part D plan.

While it is very unlikely anyone under the Active Plan will be on Medicare Part D coverage, you should know our special coordination rule. Specifically, if you are an Active Member and a Medicare-eligible individual, and you choose to obtain Medicare Part D coverage, you *cannot* also have the Fund's prescription drug coverage. You will lose your Fund prescription drug coverage as of the date of your eligibility in the Medicare Part D program.

If you wish to cancel your Medicare Part D coverage and re-enroll in the Fund's prescription drug program, you would be given a *once-in-a-lifetime opportunity* to do so. If you should have any questions about the Fund's prescription drug program and Medicare Part D, please contact the

Fund Office.

Enroll in Medicare Parts A and B as soon as you are eligible.

When you are eligible, the Plan treats you as if you were enrolled in Medicare, so you should enroll to keep your expenses down.

Information About Medicare

Medicare is a four-part program. The first part is officially called “Hospital Insurance Benefits for the Aged and Disabled,” and is commonly referred to as Part A of Medicare. The second part is officially called “Supplementary Medical Insurance Benefits for the Aged and Disabled,” and is commonly referred to as Part B of Medicare. Part A of Medicare primarily covers hospital benefits, although it also provides other benefits. Part B of Medicare primarily covers physician’s services, although it, too, covers a number of other items and services. Part C of Medicare is called Medicare+Choice and covers Medicare managed care offerings. If you are covered by a managed care plan, the Plan will presume that you have complied with the managed care program’s rules necessary for your expenses to be covered by the managed care program. Part D of Medicare is the Medicare Prescription Drug Program.

If you do not enroll for Part B coverage within the three months after becoming age 65, and you stop working or lose eligibility for Plan benefits, you may enroll for Part B coverage through Medicare within seven months of the first day of the first month in which you are no longer covered by the Plan without any penalty or waiting period. If you are such an individual and you do not enroll for Part B coverage within

this seven month period, you may enroll during the “general enrollment period.” This “general enrollment period” occurs between January 1 and March 31 of each year and coverage begins the following July 1.

The monthly premium will be assessed a 10% increase for each full 12 months (after age 65) you are not enrolled in Part B coverage. However, months during which you were covered by the Plan are not counted.

It’s your (and any eligible dependent’s) responsibility to apply for Medicare Part A and Part B. If you or your eligible dependent is eligible for Medicare and want information about enrollment, contact your local Social Security Administration Office three months before your 65th birthday or when you are otherwise eligible for Medicare. Contact your local Social Security Administration Office if you have questions concerning Medicare eligibility, enrollment, or coverage. To contact Medicare, the toll free telephone number is 1-800-MEDICARE (633-4227).

Reimbursement

The Fund is not liable for any health expenses or costs, including Weekly Disability Benefits (we will refer to all of these as “Expenses”), incurred under this Plan due to illness or injury caused by third parties. The Fund may, however, pay or advance Expenses incurred subject to the reimbursement requirements listed below. The Fund may require you or your eligible dependents, including any legal representative of such an individual, to sign a reimbursement agreement before any Expenses are paid or advanced to any service provider or any other individual or entity.

Regardless of whether you or your eligible

dependents, or any legal representative, have signed a reimbursement agreement, if expenses are paid or advanced under this Fund and you have a claim against one or more insurance companies and/or one or more parties who may be responsible or liable for the cost of such Expenses paid or advanced by the Fund, the Fund must be repaid out of any proceeds received by you or your eligible dependents or your legal representative (or any other entity on behalf of any such individual) from the other party or parties or from any insurer, whether by way of settlement of the claim or by way of judgment, whether denominated for medical expenses, pain and suffering, or any other category, without any reduction or adjustment for attorney fees, and even if you or your eligible dependent is not made whole.

The Fund will have a first priority and an equitable interest (lien) in any amount recovered or to be recovered by you or your eligible dependent(s). If it is necessary that the Fund institute legal action against you or your eligible dependent because you fail to repay the Fund as required or honor the equitable interest in any amount recovered by you or your eligible dependent from any insurer or other party, you are liable for interest on the amount due, at a reasonable rate per month, established by the Fund, beginning 30 days after settlement, judgment or award and for all costs of collection, including reasonable attorney's fees.

In addition to the above, if any payment is made from any source to you or your eligible dependent and the Fund has not been reimbursed as required, the Fund may withhold payment on claims to you or any eligible dependent in your family until the Fund has been reimbursed for the amount it paid in Expenses, other costs and any legal fees.

Once a claim has been reduced to a judgment, award or settlement, the general rule is that the Fund **will not** pay future benefit claims for you (or an eligible dependent of yours) that are related to the applicable injury or illness. However, effective for judgments, awards and/or settlements on and after April 1, 2010, there is a limited exception in situations where the Fund is reimbursed in full for all Expenses, and the Fund determines, with the consultation of its Medical Consultant (if warranted), that the applicable individual has achieved maximum recovery for his or her particular injury or illness. If the requirements of this limited exception are met, the Fund would pay future benefit claims relating to a third party case, assuming the individual is otherwise eligible for Fund coverage at the time future claims are made. Call the Fund Office (see page 5) for more information about this limited exception and its various requirements.

Amounts paid to you or your eligible dependents by the Connecticut Victim's Fund are not subject to the Plan's reimbursement rules.

Other Reimbursements; Mistake, etc.

On rare occasions, the Fund may pay benefits to an individual or other entity (such as an estate) which is not otherwise entitled to them. Such benefits may be paid due to a simple mistake or error, due to intentionally misleading information or statements, or due to other causes too numerous to mention. In such a situation, the individual, the individual's estate, or any Eligible Individual through whom the individual claimed Plan benefits will be liable to repay all amounts paid by the Fund and all costs of collection, including interest and attorney's fees. The Fund also has the right to deny or offset any future Plan benefits which would otherwise be paid until all amounts have been reimbursed or recovered.

Compliance with the Federal Health Care Reform Law and Other Laws

The Plan has made, and will be making in the future, a number of changes to comply with the Patient Protection and Affordable Care Act of 2010 or the "Affordable Care Act." You have likely heard that a number of legal challenges have been brought which challenge the constitutionality of the Affordable Care Act. On top of that, legislation is being proposed to repeal and/or modify the Affordable Care Act. Likewise, the United States government recently indicated that it will not defend the constitutionality of a federal law which relates to the Plan's definition of Spouse, which is the federal Defense of Marriage Act. As can be seen, this is a very difficult time to be administering a health plan like ours, but we will continue to monitor all applicable legal developments with the assistance of the Fund's professionals and Legal Counsel.

With that said, despite what any individual may think about these laws and health care in general, it is the duty of the Fund's Trustees to comply with applicable federal law, and they will continue to do so. In the event an applicable law is repealed or modified, or declared unconstitutional or illegal by a court of competent jurisdiction and all applicable appeals are exhausted, the Trustees will take appropriate steps to comply with applicable federal law(s) that is (or are) in effect.

Privacy Policy

The Plan is required to protect the confidentiality of your protected health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. You may request a complete description of your rights under the Plan's privacy

policies and procedures and free of charge at the Fund Office.

Protected Health Information (PHI) includes all individually identifiable health information transmitted or maintained by the Plan.

Your rights under HIPAA include the right to:

1. Receive confidential communications of your health information, as applicable;
2. Copy your health information at a cost;
3. Receive an accounting of certain disclosures of your health information;
4. Amend your health information under certain circumstances; and
5. File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact the Fund Office.

PLEASE NOTE

In order for the Fund Office staff to speak with family members (i.e. mother, father) regarding claims or eligibility of an eligible child who is age 18 or older, that dependent must complete a HIPAA Representative form allowing us to do so. Once that properly completed form is returned to the Fund Office, Fund representatives can speak with the designated family member(s) about that child's claims.

Uses and Disclosures

The Trustees, as the Plan Sponsor of the Plan, may use and disclose protected health information (PHI) only to the extent allowed, and in accordance with the uses and disclosures permitted, by HIPAA.

Specifically, the Plan may use PHI, and disclose PHI to the Trustees:

- For purposes related to treatment, payment, and health care operations, as those terms are defined in HIPAA or applicable regulations; or
- As permitted by you or your eligible dependent's written authorization.

With respect to PHI, the Trustees agree to:

- Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agent, including a subcontractor, to whom they provide PHI received from the Plan agrees to the same restrictions and conditions that apply to the Trustees with respect to PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Trustees;
- Report to the Plan if any of them become aware of any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in this section;
- Make available PHI in accordance with Federal Regulations for purposes of providing access to inspect or copy PHI, amend PHI, or request disclosures of PHI;

- Make the Trustees internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for determining compliance by the Plan with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that any of them still maintains in any format and retain no copies of the information when no longer needed for the purposes for which disclosure was made, except that, if the return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure adequate separation, as described above, between the Plan and the Trustees.

Adequate Separation

Unless otherwise authorized or restricted by you or your eligible dependent, the Plan may give access to PHI to the following members of the Fund's workforce to the extent noted below:

- Global access to Health Claims Supervisor and Health Fund staff who handle health claims.
- Limited access to:
 - Privacy Official as needed to implement, monitor and administer HIPAA Privacy Policies and Procedures;
 - Executive Director and Controller to oversee Fund administration;
 - Health Fund clerical employees whose primary function is sorting claims, filing and support; and

- Fund Office staff who provides administrative support services to the Fund such as billing, accounting and information technology services,

Minimum Necessary

Any PHI used or disclosed to the Trustees, the classes of employees listed above or to Business Associates will be the minimum necessary to perform their respective duties with regard to the Plan in accordance with the Plan's Minimum Necessary Policies and Procedures.

Hybrid Entry

Because the Plan has designated both health care and non-health care components (that include Death, AD&D and Weekly Disability benefits), it is a "hybrid entity" as that is defined by HIPAA, and the two components will be treated as separate legal entities under HIPAA. The Fund's workforce will not use or disclose PHI it receives from the health care component to adjudicate claims under the non-health care component.

Noncompliance

If the Fund discovers noncompliance with its HIPAA Privacy Policies and Procedures, complaint, investigation, initiation and sanctions as appropriate, will be governed by the relevant sections of the Fund's HIPAA Privacy Policies and Procedures.

Name of Plan

The name of the Plan is
***International Union of Operating Engineers
 Local No. 478 Health Benefits Plan.***

Board of Trustees

A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of: (i) Employer representatives selected by the Employer Association, and (ii) Union representatives selected by the International Union of Operating Engineers Local No. 478. The Trustees of this Plan as of the printing of this booklet are:

UNION TRUSTEES	EMPLOYER TRUSTEES
<p>Christopher Cozzi International Union of Operating Engineers Local No. 478 Health Benefits Plan 1965 Dixwell Avenue Hamden, CT 06514-2400</p>	<p>John T. Leahy Connecticut Construction Industries Association, Inc. 912 Silas Deane Highway Wethersfield, CT 06109</p>
<p>Craig Metz International Union of Operating Engineers Local No. 478 Health Benefits Plan 1965 Dixwell Avenue Hamden, CT 06514-2400</p>	<p>John Olender, Sr. John Olender Corporation Tolland Industrial Park Tolland, CT 06084</p>
<p>Philip Rapuano International Union of Operating Engineers Local No. 478 Health Benefits Plan 1965 Dixwell Avenue Hamden, CT 06514-2400</p>	<p>Thomas J. Oneglia O & G Industries, Inc. 112 Wall Street Torrington, CT 06790</p>

Plan Sponsor and Plan Administrator

The Board of Trustees is both the Plan Sponsor and Plan Administrator. The Board of Trustees employ and maintain a Fund Office and staff to perform routine administration of the Plan.

Identification Numbers

The number assigned to this Plan is 501. The Employer Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 06-0662089.

Agent For Service of Legal Process

The Plan Administrator, commonly known as our Executive Director, is Mr. Daniel E. Krause, and he is the agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents may be served upon Mr. Krause at:

Mr. Daniel E. Krause
International Union of Operating Engineers
Local No. 478 Health Benefits Plan
1965 Dixwell Avenue
Hamden, CT 06514-2400

In addition, legal process may be served upon any Fund Trustee at the address listed immediately above.

Source of Contributions

Employer contributions, COBRA self-payments, and other self-payments (e.g., retiree contributions through the Plan's retiree programs) are received and held in trust by the Trustees pending payment of benefits and administrative expenses. The Plan generally provides benefits on a "self-insured" basis, meaning that benefits are paid from a trust fund. However, the Plan does provide its life insurance (i.e., its Death benefits) and its accidental death and disability (AD&D)

benefits through an arrangement with an insurer, currently Reliance Standard.

Employer contributions toward the cost of the Plan are made by employers who have entered into Collective Bargaining Agreements with the Union or participation agreements with the Trustees. Contact the Fund Office for a list of Contributing Employers.

Type of Plan

The Plan, considered a welfare plan, is maintained for the purpose of providing medical, prescription drug, dental, vision, disability, death, AD&D, and other listed benefits. The Plan benefits are shown in the "Schedule of Benefits" on page 7.

Trust Fund

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants and beneficiaries and defraying reasonable administrative expenses. The Fund's assets are managed by professional asset managers selected by the Board of Trustees.

Eligibility

The Plan's requirements with respect to active eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described fully in this booklet. Participation in the Plan or eligibility for benefits is not a guarantee of employment.

The Fund's Board of Trustees is granted the discretionary authority to determine eligibility for benefits and to construe the terms of the Plan. As a result, determinations by the Board of Trustees will receive judicial deference to the extent they are not arbitrary and capricious.

Claim Procedure

The procedures to follow for filing a claim for benefits are listed on pages 79-85 of this booklet. If all or any part of a claim is denied, you have the right to request that the Board of Trustees review the matter.

Plan Year

The records of the Plan are kept separately for each Plan Year. The Plan Year begins on January 1 and ends on December 31 of the same calendar year.

Plan Amendment or Termination

This Plan may be amended, changed, or discontinued at any time without the consent of any Eligible Individual by a majority vote of those Trustees present and voting at a meeting where a quorum is present. An amendment may be effective prospectively or retroactively and is subject to the limitation of the Trust Agreement and to applicable law and administrative regulations.

If the Plan is modified or terminated, you will be notified in writing or as required by law. In addition, the Trust may be terminated as a result of the expiration of all Collective Bargaining Agreements requiring payment of contributions to the Fund, or for any other reason deemed necessary by the Trustees.

In the event of a termination, any and all assets remaining after the payment of all obligations and expenses will be used, in accordance with a plan for dissolution adopted by the Trustees, to continue the benefits provided by the existing Plan until such assets have been exhausted or in such manner as will best serve the purposes of the Fund. In no event will assets be paid to or be recoverable by any participating employer, association, or labor organization.

Statement of ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These include insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and Collective Bargaining Agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description and Plan Document. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when:
 - You lose coverage under the Plan;
 - You become entitled to elect COBRA continuation coverage; or
 - Your COBRA continuation coverage ceases.

Keep your Certificate of Creditable Coverage in a safe place, as it may help you obtain health coverage under another group health plan or health insurance policy and/or avoid pre-existing condition exclusions from applying to you.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No

one, including your employer, your Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Summary Plan Description and Plan Document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you

lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

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

For more information or to request publications about your rights and responsibilities under ERISA:

- Call (866) 444-3272; or
- Visit **www.dol.gov/ebsa**.



Definitions



Active Member or **Member** means an employee who has satisfied the Plan's eligibility rules.

Alumni means employees who are officers, supervisors, directors, or stockholders of contributing employers and who meet the following criteria:

- The employee works in bargained work more than 50% of his or her total working hours, and, with respect to the remainder of his or her employment for the contributing employer, the employment relates to the contributing employer's work in the construction industry, none of which is in Non-Covered Employment;
- The employee is or was a member of a unit of employees covered by a Collective Bargaining Agreement;
- A Collective Bargaining Agreement (or a Participation Agreement for this purpose) provides for the employee to benefit under the Plan, and the agreement provides that the employee will be treated generally no more favorable, as to contributions made and benefits accrued under the Plan, than similarly situated employees who worked in Bargained Work;
- The employee has not acted, and does not act, as an employer in labor-management matters, except for signing of collective bargaining or similar agreements as agent for the contributing employer, and has not served, and does not serve, as a management representative on any arbitration, mediation or grievance panel;
- The employee has been designated as an Alumnus by the Contributing Employer in such non-discriminatory manner as the Trustees may require; and

- The employee has not previously lost his status as an Alumnus of the designating Contributing Employer.

Bargained Work means work in Covered Employment that is governed by a Collective Bargaining Agreement.

Beneficiary means a person named to receive Death benefits and/or AD&D benefits in the event of death under this Plan because of that person's designation for such benefits by an Active Member.

Certificate of Creditable Coverage means a certificate which must be furnished under HIPAA by the Fund to an individual who loses Fund coverage. You may also request such a certificate in writing within 24 months of the date you lost your Fund coverage. The certificate generally documents the period of time the particular individual was covered by the Fund.

Child means, in addition to biological or lawfully adopted child, any stepchild or foster child of a Member. A stepchild is a child from a former marriage of a Member's Spouse, and a child is considered "lawfully adopted" if he or she is legally adopted by, or lawfully placed for adoption with, a Member. If a Member's Spouse has had a child out of wedlock prior to the Spouse's marriage to the Member, the term "child" will include such a child, provided that the Fund Office has been provided with evidence of the Spouse's paternity or maternity of such child. The term "child" also includes a grandchild, provided that the grandparent/Member has legal custody of such grandchild.

Chiropractor means, with respect to chiropractic services, a holder of a validly issued state certificate or license authorizing that individual to perform chiropractic services in the jurisdiction where the services are performed.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, which was a federal law that established, among other things, the continuation coverage rules for group health plans that are regulated by ERISA.

Co-Insurance means a cost-sharing arrangement under our Plan where eligible individuals pay a specified percentage of the cost (normally 20%) of a specified service.

Collective Bargaining Agreement means any written agreement, including any extensions or renewals thereof, between a contributing employer and the Union, which describes the terms and conditions of work in the jurisdiction of the Union and under which the contributing employer is required to make contributions to the Fund.

Contributing Employer or Employer means any person, firm, corporation, or other entity who or which employs members of the Union or other employees, is signatory to a Collective Bargaining Agreement, and obligated to make contributions to the Fund on behalf of members or other employees. The term also includes, subject to the approval of the Trustees, the Union, an employee benefit fund, or, with respect to Alumni only, any other corporate entity that employs Alumni, which is obligated to contribute on behalf of its employees pursuant to a written Participation Agreement with the Fund.

Copayment or Co-pay means a dollar amount which an Eligible Individual must pay out of his/her own pocket in order to receive benefits under this Plan. Two common examples are the \$25 co-pay for an in-network physician office visit, and the \$30 co-pay for a brand prescription drug from a retail pharmacy.

Covered Employment means employment of an employee by a Contributing Employer who is obligated under a Collective Bargaining Agreement or Participation Agreement to contribute to the Fund on the employee's behalf for the employment.

Covered Medical Expenses or Covered Expenses means the charges incurred by an eligible Individual for treatment or services for which a benefit is payable under the terms of this Plan. Covered Medical Expenses include any surcharges, taxes, or similar amounts that are imposed by a federal, state or regulatory agency for such treatments or services.

Custodial Care means all services and supplies, including room and board, which are provided, whether the eligible Individual is disabled or not, primarily to assist in the activities of daily living. Such services and supplies are custodial care regardless of the practitioner or provider by whom they are prescribed, recommended, or performed. Some examples of custodial care are: assistance in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine.

Deductible (applies to out-of-network only) means the amount of covered medical expenses which you or your eligible dependents must first pay in a Plan Year before you or they would be entitled to benefits under the Plan. The applicable individual and family deductibles of this Plan per Plan Year is listed in the "Schedule of Benefits."

Dentist means a person authorized by law and duly licensed to practice the prevention, diagnosis and treatment of diseases, injuries and malformations of the teeth, jaws and mouth, and includes a dentist who is performing surgical services within the lawful scope of his or her license.

Eligible Child means a child who meets the qualifications to be an Eligible Dependent of a Member.

Eligible Dependent means:

- A Member's Spouse;
- A Member's child from the date of birth to the last day of the month which includes the child's 26th birthday, provided that during the period from January 1, 2011 through December 31, 2013, a child who is age 19 or older will not qualify as an Eligible Dependent if such child is eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of the child's parent.
- The Plan also has two special rules for a Member's child with a medically determinable physical or mental impairment (what we refer to below as a "Disability"):
 - Immediately prior to January 1, 2011, the Plan would provide coverage for an unmarried child of a Member while the Member had coverage, regardless of the child's age, provided that the child was both: (i) dependent on the Member for a substantial portion of his or her maintenance and support, and (ii) incapable of self-sustaining employment because of a Disability that commenced prior to the child's 19th birthday. The Member was required to submit proof

of the child's dependent status and Disability to the Fund Office no later than 30 days before the date the child attained age 19. If a Member did not provide applicable proof to the Fund Office as noted, then the child's coverage would end under the Plan's rules as then in effect. A Member is permitted to reinstate coverage for a child described in this paragraph on a prospective basis only by notifying the Fund Office of the child's continued Disability. The Member must provide applicable proof to the Fund Office.

- On and after January 1, 2011, the Plan will provide coverage for a Child of a Member while the Member has coverage, regardless of the child's age, provided that the child is incapable of self-sustaining employment because of a Disability that commenced prior to the child's 26th birthday. The Member is required to submit proof of the Child's Disability to the Fund Office no later than 30 days before the date the child attains age 26. If a Member does not provide applicable proof to the Fund Office as noted, then the child's coverage under the Plan will end in accordance with the normal rules for Eligible Dependents as described in this booklet. A Member is permitted to reinstate coverage for a child described in this paragraph on a prospective basis only by notifying the Fund Office of the child's continued Disability. The Member must provide applicable proof to the Fund Office.

NOTE

If you are a Member who has a child with a Disability who could qualify for coverage under either paragraph, we urge you to contact the Fund Office immediately!

Eligible Individual means a Member, and any Eligible Dependents of a Member.

Employee means:

- A person (other than: (1) a self-employed person, (2) a partner, (3) a sole proprietor, (4) a person who owns more than 25% of the stock of a Contributing Employer, or (5) a person who is a member of a limited liability corporation with fewer than four members, unless such person qualifies as an Alumni) employed in bargained work by a Contributing Employer;
- Subject to the approval of the Trustees, a person employed for 1,000 or more hours during a Plan Year by the Union or a related employee benefit fund that is a Contributing Employer; and
- Alumni.

Engineers Family Assistance Program or EFAP means a professional consultation and referral program established by the Plan, currently managed by MHN, (the Gatekeeper), is designed to direct and monitor the treatment for personal and family problems, mental/nervous disorders and alcohol and substance abuse.

ERISA means the federal Employee Retirement Income Security Act of 1974, as amended, which governs all aspects of the administration, supervision, and management of both pension plans and welfare (health) plans.

Essential Health Benefit means those types of benefits described in Section 1302(b) of the Affordable Care Act and regulations issued pursuant thereto, including at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization;

maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental, Investigational or Unproven Procedures means any medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Plan makes a determination regarding coverage in a particular place, is determined to be:

- a) Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use or not identified in a Center for Medicaid and Medicare Services (CMS)-approved compendia as appropriate for the proposed use; or
- b) Subject to review and approval by any Institutional Review Board for the proposed use; or
- c) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or the experimental arm of a phase 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- d) Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Plan, in its judgment, may deem an Experimental, Investigational or Unproven service a covered Medical Expense for treating a life threatening sickness or condition if it is determined by the Plan, with advice from its medical consultant and Utilization Management Vendor, that the Experimental, Investigational or Unproven Service at the time of the determination:

- a) is safe with promising efficacy; and
- b) is proved in a clinically controlled research setting; and
- c) uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term “life threatening” is used to describe sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.)

Fund or Trust Fund means the International Union of Operating Engineers Local No. 478 Health Benefits Fund as established by the Agreement and Declaration of Trust.

Gatekeeper means the EFAP designated by the Plan to screen and refer for treatment eligible Individuals with mental/nervous and/or alcohol/substance abuse problems.

Health Benefits Plan, Health Plan or Plan means the International Union of Operating Engineers Local No. 478 Health Benefit Plan, as set forth in this document, together with any subsequent amendments.

HIPAA means the federal Health Insurance Portability and Accountability Act of 1996, which is far-reaching legislation designed to improve the portability of health coverage, reduce health care costs by standardizing the processing of health care transactions, increase the security and privacy of health care information, and to make other changes to the health care delivery system.

Hospice means an agency that provides counseling and incidental medical services for terminally ill individuals on an inpatient or in-home basis. Room and board may be provided.

The agency must meet all of the following tests:

- It is approved under any required state or governmental Certificate of Need or similar licensing requirement;
- It provides 24 hour-a-day, seven day-a-week service;
- It is under the direct supervision of a physician;
- It has a nurse coordinator who is a registered nurse with four years of full-time clinical experience. At least two of the four years must involve caring for terminally ill patients;
- It has social-service coordinator who is licensed in the area in which the agency is located;
- The main purpose of the agency is to provide hospice service;
- It has a full-time administrator;
- It maintains written records of services provided to the patient;

- Its employees are bonded and it provided malpractice and misplacement insurance; and
- It is established and operated in accordance with all applicable state and federal laws.

Hospital means an institution that:

- It is primarily engaged in providing, by or under the supervision of physicians, in-patient medical services for the diagnosis, treatment, or rehabilitation of injured, disabled, or sick individuals;
- Maintains clinical records on all patients;
- Has by-laws in effect with respect to its staff of physicians;
- Has a requirement that every patient be under the care of a physician;
- Provides a 24-hour nursing service supervised by a registered graduate nurse;
- Has in effect a hospital utilization review plan;
- Is licensed by the state or agency of the state responsible for licensing hospital; and
- Has accreditation under one of the programs of the Joint Commission on Accreditation of Health Care Organization.

Unless specifically provided, the term “hospital” does not include any institution that is used principally as a rest facility, nursing facility, convalescent facility, or facility for the aged or for the case and treatment of drug addicts or alcoholics, nor does it mean any institution that provides medical services for which you or your eligible dependent is not required to pay.

Illness means any sickness, disorder, or disease. Subject to applicable Plan rules, any illness will be considered for benefits under this Plan, including pregnancy.

Injury means any physical damage to the body due to an accident or accidental means, independent of all other causes. Subject to applicable Plan rules, any injury will be considered for benefits under this Plan.

Maximum Allowable Cost or “MAC” has the same meaning as the term Reasonable and Customary (see page 107).

Medically Necessary means any service, supply, treatment or hospitalization that:

- Is essential for the diagnosis or treatment of the injury or illness for which it is prescribed or performed;
- Meets generally accepted standards of medical practice; and
- Is ordered by a physician.

In addition, services, supplies, treatment or hospitalization will not be considered “medically necessary” if they are an Experimental Procedure, or primarily limited to research in their application to the injury or illness; or if primarily for scholastic, educational, vocational or developmental training; or if primarily for the comfort, convenience or administrative ease of the provider or the patient or his or her family or caretaker.

The Trustees or their delegate, in consultation with the Fund's Medical and/or Dental Consultants or Consultants, reserve the right to review medical care and to make a determination as to whether any service, supply, treatment or hospitalization, is or is at medically necessary. The fact that a physician or any other health care provider, including those who participate in the Fund's PPO, may prescribe, order, recommend, or approve a service, supply, treatment, or hospitalization does not, of itself, make it medically necessary or a covered medical expense. The same principles would apply in determining whether a prescription drug is covered by the Plan.

Mental Disorder means a nervous or mental condition that meets all of the following conditions:

- It is a clinically significant behavioral or psychological syndrome or pattern; and
- It is associated with a painful symptom, such as distress; and
- It impairs the patient's ability to function in one or more major life activities; and
- It is a condition listed in the Axis I Disorders (except for V codes) of the Diagnostic Manual of Mental Disorders by the American Psychiatric Association, currently DSM-IV, as updated and revised from time to time.

Non-Covered Employment means:

(i) employment anywhere in the United States in a category of work that would require contributions to the Fund but for the fact that the employer is not a signatory to a Collective Bargaining Agreement, and includes acting as an officer, director, supervisor, stockholder or

in a similar capacity for such an employer, but excludes employment that is performed by an employee of the Union at the exclusion direction of the Union; or (ii) any self-employment, whether as a partner, proprietor, or otherwise, as an operating engineer in the United States.

Non-Essential Health Benefit means those types of benefits that do not qualify as Essential Health Benefits. Within general categories, coverage of a specific item or service may be determined to be either Essential or Non-Essential.

Nurse means a Registered Graduate Nurse ("R.N."), Licensed Practical Nurse ("L.P.N."), or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," or L.P.N.

Organ or Tissue Transplant means the medically necessary removal of a human organ (i.e., heart, lung, or liver) or tissue (i.e., bone marrow) and the insertion of a replacement organ or tissue through surgical means.

Participation Agreement means a written agreement between the Fund and the Union, a related employee benefit fund, or, with respect to Alumni only, a business entity that employs Alumni, which sets forth the under which those employers are obligated to contribute to the Fund on behalf of their respective employees.

Pharmacy means a state licensed establishment where prescription drugs are dispensed by a pharmacist.

PHI or Protected Health Information means all individually identifiable health information relating to your past, present or future physical or mental health condition or to payment for health care. Under HIPAA, PHI includes information maintained by the Plan in oral, written or electronic form. The Plan safeguards your PHI in accordance with the requirements of HIPAA.

Physician means a doctor of medicine, osteopathy, or optometry, and a dentist, performing medical or surgical services within the lawful scope of his or her license

Plan Year means the period of 12 consecutive months beginning January 1 and ending on December 31 of the same year.

Reasonable and Customary means an amount charged in connection with health care treatment that is Medically Necessary and does not exceed the amount normally and ordinarily charged for similar and comparable medical services, treatments and/or supplies by other service providers in the locality where the medical services, treatments and/or supplies are provided. In determining whether a particular charge is reasonable and customary, due consideration will be given to the nature and severity of the condition being treated and any complications or unusual circumstances that require additional time, skill or experience. The Trustees or Fund representatives may consult with the Fund's Medical Consultant in making such determinations. The Plan normally utilizes data provided by New York Medical Management and Anthem Health Plans, Inc. for out-of-network charges.

Skilled Nursing Services means one or more of the services that may be rendered by a Nurse.

Spouse means a person to whom a Member is lawfully married by virtue of a marriage between one man and one woman. This is the definition of marriage under the federal Defense of Marriage Act, which is consistent with the fact that this Plan is governed by federal law (ERISA). An individual who is legally separated, who is a "common-law" spouse, or who is a party to a same-sex marriage under Connecticut law, is not treated by the Plan as lawfully married.

Surgery or Surgical Procedure means any procedure in the categories listed below:

- The incision, excision, or electro cauterization of any organ or part of the body;
- Manipulative reduction of fracture or dislocation;
- The removal by endoscopic means of a stone or other foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder, or ureter;
- Laser treatment to correct a congenital vascular malformity; or
- For eligible individuals other than eligible children, the insertion on an intrauterine device.

Termination for Cause means the loss of eligibility for Plan benefits whenever any Eligible Individual, or an individual covered under the Plan's COBRA provisions, engages in any of the following activities:

- Committing a crime (regardless of whether he or she is ultimately convicted) against the Fund, any employee benefit fund related to the Fund, the Union, any Employer, or any of their respective officers, directors, trustees, employees or agents; or
- Making, giving or withholding, whether directly or indirectly, any information, including a false or misleading statement, for the purpose to inducing the Fund to make an individual eligible for a benefit under the Plan that he or she would not otherwise been eligible to receive.

Trust Agreement means the Agreement and Declaration of Trust, as amended from time to time, establishing the International Union of Operating Engineers Local No. 478 Health Benefits Fund under which this Plan is established and by which it is governed.

Trustees or Board of Trustees means the Board of Trustees as established and constituted from time to time in accordance with the Trust Agreement.

Union means Local No. 478 of the International Union of Operating Engineers.



Board of Trustees

International Union of Operating Engineers

Local No. 478 Health Benefits Fund

Employer Trustees

John T. Leahy
Connecticut Construction
Industries Association, Inc.
912 Silas Deane Highway
Wethersfield, CT 06109

John Olender, Sr.
John Olender Corporation
Tolland Industrial Park
Tolland, CT 06084

Thomas J. Oneglia
O & G Industries, Inc.
112 Wall Street
Torrington, CT 06790

Union Trustees

Christopher Cozzi
I.U.O.E. Local No. 478
1965 Dixwell Avenue
Hamden, CT 06514-2400

Craig Metz
I.U.O.E. Local No. 478
1965 Dixwell Avenue
Hamden, CT 06514-2400

Philip Rapuano
I.U.O.E. Local No. 478
1965 Dixwell Avenue
Hamden, CT 06514-2400

