



Your

Retiree

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**

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**Health Benefits Fund**

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*Fund Auditors*         **Schultheis & Panettieri, LLP**

*This Summary Plan Description has been prepared for Retirees 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 information regarding the Retiree Health Benefits provided under 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 Retiree Health Benefits. In general, the benefits described in this booklet are effective January 1, 2011. ***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 Retiree Benefits Program, you're eligible for a generous package of health benefits. The Health Benefits Plan offers:

- Comprehensive medical coverage with an emphasis on wellness and preventive care;
- Top-notch dental, vision and prescription drug coverage; and
- A higher percentage paid by the Plan when you use an in-network PPO provider.



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Under the Plan, there are two programs providing Retiree Health Benefits:

- **Pre-Medicare Retiree Benefits Program** for retirees who retire at or after age 60 (or earlier if disabled); and
- **Medicare Supplemental Retiree Benefits Program** for Medicare-eligible Retirees age 65 or older (or earlier if disabled).

It is the Trustees' goal to maintain a financially stable Fund while providing adequate health care coverage to our Retirees. 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 52 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.

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**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  
or  
(866) 288-9261 (toll free)**

- **Watching for fraud!** Always keep your Social Security Number 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.

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.

Overall, the Plan provides Medical, Hospital, Dental, Vision, and Death benefits.

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](http://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, copayments, 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 ...
<p><b>- Locating A PPO Provider</b> (Pre-Medicare participants only)</p>	<p>Anthem BlueCross BlueShield Telephone: (800) 810-2583 Web site: <a href="http://www.anthem.com">www.anthem.com</a></p>
<p><b>- Pre-Certification of Inpatient Hospital or Rehabilitation Care</b> (Pre-Medicare participants)</p>	<p>Hines &amp; Associates Telephone: (800) 323-3454 Web site: <a href="http://www.hinesassoc.com">www.hinesassoc.com</a> (Click on "online referrals" at the top of the screen)</p>
<p><b>- Medical Benefits And Claims</b> <b>- Vision Benefits (Indemnity)</b> <b>- Prescription Drug Claims</b> <b>- Death Benefits</b></p>	<p>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)</p>
<p><b>- Prescription Drug Program</b></p>	<p>CVS/Caremark Telephone: (888) 790-8084 Web site: <a href="http://www.caremark.com">www.caremark.com</a></p>
<p><b>- Vision Benefits (through network)</b></p>	<p>Davis Vision Network Telephone: (800) 999-5431 (To locate a provider) Web site: <a href="http://www.davisvision.com">www.davisvision.com</a></p>
<p><b>- Behavior Health Benefits</b> Pre-Medicare participants must contact MHN to pre-certify any inpatient care</p>	<p>MHN Telephone: (800) 624-6864</p>
<p><b>- Dental Benefits</b></p>	<p>Delta Dental of New Jersey Telephone: (800) 452-9310 (to locate a network provider: (800) DELTAOK) Web site: <a href="http://www.deltadentalnj.com">www.deltadentalnj.com</a></p>





## 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 35).
- 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 a Retiree

<b>Plan Year</b>	The Plan utilizes the calendar year (January 1st through December 31st) as its Plan Year.	
<b>Annual Maximum Benefit (2011-2013 only)</b>	<p>\$750,000 per Eligible Individual for the 2011 Plan Year, increasing to \$1.25 million per Eligible Individual for the 2012 Plan Year, and \$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- and out-of-network benefits. For purposes of tracking the AMB 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 Active Plan, and retiree benefits obtained prior to and after Medicare eligibility.</p>	
<b>General Benefit Formula Used to calculate benefits, except where otherwise indicated</b>	<i><b>In-Network</b></i>	<i><b>Out-of-Network</b></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*)

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\* 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 37 for more information about MAC.

\*\* Where multiple services are provided by the same provider on the same day, the highest single co-pay will apply.

### Introduction to the Schedule of Benefits

**As a general rule for the Medicare Supplemental Retiree Benefits Program, the Fund pays 90% after Medicare on most of the following services. Copayments do not apply for participants who have Medicare coverage as primary payer EXCEPT for prescription drug purchases.**

## Section I. Preventive Care

Benefit	In-Network	Out-of-Network
<b>Physical Exam Benefit (Routine)</b>	Limit of 2 per Plan Year—Encompassing both in- and out-of-network. Eligible Member and Spouse only—includes OB/GYN visit for eligible female Retiree or Spouse. Lab work associated with Physical Exam paid under X-ray/lab benefit.	
	\$25 copayment per visit. Lab work and covered immunizations are paid under X-ray/ lab and immunizations benefit.	80% after deductible, subject to MAC. Lab work and covered immunizations are paid under X-ray/lab and immunizations benefit.
<b>Well Child Benefit</b>	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).  For both in- and out-of-network, the following schedule applies:  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*  <i>* A year is measured from child’s birthday to the day before his/her next birthday.</i>	
	\$25 copayment per visit. Lab work and covered immunizations are paid under X-ray/lab and immunizations benefit.	80% after deductible, subject to MAC. Lab work and covered immunizations are paid under X-ray/lab and immunizations benefit.
<b>Routine Immunizations</b>	Eligible Retiree, 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:  <b><a href="http://www.cdc.gov/vaccines/recs/schedules/default.htm">http://www.cdc.gov/vaccines/recs/schedules/default.htm</a></b>	
	100% of covered expenses.	80% after deductible, subject to MAC.

<b>Benefit</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Conditional Immunizations</b>	Eligible Retiree, 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.
<b>Dietary Counseling Benefit</b>	Eligible Retiree, 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.
<b>Routine Screening Mammography</b>	<p>Eligible Retiree and Spouse only. Mammography associated with a diagnosis is paid under the X-ray/lab benefit.</p> <p>From 35th birthday to day before 40th birthday—1 occurrence allowed                      Age 40 and older—1 occurrence every year*</p> <p>These limits encompass both in- and out-of-network benefits.</p> <p><i>*A "year" is measured from an individual's birthday to the day before his or her next birthday.</i></p>	
	\$25 copayment per occurrence, then the Plan pays 100% of covered expenses.	80% (no deductible), subject to MAC.

## Section II. General Medical Care

<b>Physician's Office Visit</b>	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
<b>Chiropractic Benefit</b>	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.
<b>Naturopath/ Homeopathic</b>	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.
<b>X-Ray/ Lab Benefits</b>	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 inpatient 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.
<b>Miscellaneous Outpatient Benefits</b>	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><b>Home Health Care Benefits</b></p>	<p>Covers charges for services rendered in the home by the following health care providers:</p> <ul style="list-style-type: none"> <li>– Nurses</li> <li>– Home Health Aides</li> <li>– Physical Therapists</li> <li>– Social Worker</li> <li>– Speech Therapists</li> <li>– Occupational Therapists</li> </ul> <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><b>Hospice Care Benefit</b></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><b>Rehab (Non-Custodial) Benefit</b></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 &amp; Associates. For pre-certification, call Hines &amp; Associates at (800) 323-3454.</p>	
	<p>100% of covered expenses.</p>	<p>80% after deductible, subject to MAC.</p>
<p><b>Infertility Benefit</b></p>	<p>Lifetime maximum benefit of \$5,000 for medical expenses related to infertility treatment for Eligible Retiree 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 Retiree and Spouse, but is tracked as to the Retiree. 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
<b>Hospital Benefit</b>	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.	
	\$105 copayment per admission, then the Plan pays 100% of covered expenses.	80% after deductible, subject to MAC.
<b>Emergency Room Benefit</b>	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.
<b>Surgeon's Benefit Major</b>	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.
<b>Surgeon's Benefit Minor</b>	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.
<b>Assistant Surgeon</b>	\$105 copayment per operative session, then the Plan pays 100% of covered expenses.	80% after 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
<b>Anesthesiologist Benefit</b> (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.
<b>Organ &amp; Tissue Transplant</b>	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.
<b>Ambulance (Ground/Air)</b>	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**

<b>Orthotics Benefit</b>	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.

Benefit	In-Network	Out-of-Network
<b>Hearing Aid Benefit</b>	Audiology test paid under X-ray/lab benefit. Limited to <b>one set of hearing devices (right and left) every 36 months</b> —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.
<b>Miscellaneous Medical Equipment/Supplies</b>	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**

<b>Dental Benefit – Administered by Delta Dental</b>	<p>COB Claims paid using primary formula (i.e., 80%/60%/40%). Maximum total Dental Benefit(s) for a Plan Year for a Retiree and any Spouse of the Retiree is limited to \$1,000. Such \$1,000 limit shall not include any Dental Benefits provided to the Eligible Child(ren) of such Retiree.</p> <ul style="list-style-type: none"> <li>– Diagnostic and Preventive—80% of negotiated fee or MAC; allows 2 cleanings/ exams per Plan Year.</li> <li>– Restorative, Crowns, Prosthodontics—60% of negotiated fee or MAC.</li> <li>– Implants—40% of negotiated fee or MAC.</li> <li>– Dentures—1 set every 5 years.</li> </ul>
<b>Orthodontia Benefit– Administered by Delta Dental</b>	<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>
<b>TMJ Benefit – Administered by Delta Dental</b>	<p>X-Rays paid under X-ray/lab benefit.</p> <p>40% of negotiated fee or MAC—Lifetime Maximum benefit of \$500.</p>

<p><b>Death Benefit</b></p>	<p>Eligible Retiree only and <b>not</b> available through COBRA. Currently paid through Reliance Standard Ins. Co. This benefit is non-taxable.</p> <p>\$5,000 payable upon death of Eligible Retiree and submission of appropriate documentation to Fund.</p> <p>NOTE: If eligibility as a Retiree is lost, Reliance Standard Ins. Co. offers a “conversion right” to an individual life insurance policy. Former Retiree 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 51.</p>					
<p><b>Vision Benefit</b></p>	<p>Eligible Retiree, 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 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="431 1213 1427 1715"> <thead> <tr> <th data-bbox="431 1213 922 1272"> <p><b>Davis Vision Plan</b></p> </th> <th data-bbox="922 1213 1427 1272"> <p><b>Indemnity Vision Plan</b></p> </th> </tr> </thead> <tbody> <tr> <td data-bbox="431 1272 922 1715"> <p>Eye Exam—100% of Cost.</p> <p>Lenses and Frames—100% of cost of frames from Plan Collection.</p> <p>Contacts—100% of cost of lenses from Plan Collection, less \$25 copayment.</p> <p>Other cost sharing rules apply.</p> </td> <td data-bbox="922 1272 1427 1715"> <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>		<p><b>Davis Vision Plan</b></p>	<p><b>Indemnity Vision Plan</b></p>	<p>Eye Exam—100% of Cost.</p> <p>Lenses and Frames—100% of cost of frames from Plan Collection.</p> <p>Contacts—100% of cost of lenses from Plan Collection, less \$25 copayment.</p> <p>Other cost sharing rules apply.</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>
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<p><b>Prescription Drug Benefit</b></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> <table border="1" data-bbox="451 583 1409 1010"> <thead> <tr> <th data-bbox="451 583 922 638">Retail Pharmacy 30-Day Supply*</th> <th data-bbox="922 583 1409 638">Mail-Order 90-Day Supply*</th> </tr> </thead> <tbody> <tr> <td data-bbox="451 638 922 779">Generic Copayment—lesser of drug cost or \$15.</td> <td data-bbox="922 638 1409 779">Generic Copayment—lesser of drug cost or \$25.</td> </tr> <tr> <td data-bbox="451 779 922 898">Brand (Formulary) Copayment—lesser of drug cost or \$30.</td> <td data-bbox="922 779 1409 898">Brand (Formulary) Copayment—lesser of drug cost or \$55.</td> </tr> <tr> <td data-bbox="451 898 922 1010">Brand (Non-Formulary) Copayment—lesser of drug cost or \$45.</td> <td data-bbox="922 898 1409 1010">Brand (Non-Formulary) Copayment—lesser of drug cost or \$85.</td> </tr> </tbody> </table> <p>*Other limits may apply.</p>		Retail Pharmacy 30-Day Supply*	Mail-Order 90-Day Supply*	Generic Copayment—lesser of drug cost or \$15.	Generic Copayment—lesser of drug cost or \$25.	Brand (Formulary) Copayment—lesser of drug cost or \$30.	Brand (Formulary) Copayment—lesser of drug cost or \$55.	Brand (Non-Formulary) Copayment—lesser of drug cost or \$45.	Brand (Non-Formulary) Copayment—lesser of drug cost or \$85.
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Brand (Non-Formulary) Copayment—lesser of drug cost or \$45.	Brand (Non-Formulary) Copayment—lesser of drug cost or \$85.									
<p><b>Behavioral Health Benefit</b></p>	<p><b>GENERAL:</b> Under the Retiree Benefits Programs, Eligible Individuals are NOT required to pre-certify with the Plan’s gatekeeper, MHN, before obtaining Behavioral Health Services. <b>However, for Pre-Medicare patients, ALL INPATIENT</b> care must be pre-certified with the Plan’s gatekeeper, MHN, by calling them at (800) 624-6864. Inpatient 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.</p> <table border="1" data-bbox="451 1461 1409 1833"> <thead> <tr> <th data-bbox="451 1461 922 1516">In-Network MHN</th> <th data-bbox="922 1461 1409 1516">Out-of-Network</th> </tr> </thead> <tbody> <tr> <td data-bbox="451 1516 922 1833"> <p>\$25 copayment per out-patient visit (\$55 for ER care) then the Plan pays 100% of covered expenses.</p> <p>\$105 copayment for inpatient admission, then the Plan pays 100% of covered expenses.</p> </td> <td data-bbox="922 1516 1409 1833"> <p>Inpatient benefits paid at 80% after deductible, subject to MAC.</p> </td> </tr> </tbody> </table> <p>*A “day” generally means hospitalization for at least four hours.</p>		In-Network MHN	Out-of-Network	<p>\$25 copayment per out-patient visit (\$55 for ER care) then the Plan pays 100% of covered expenses.</p> <p>\$105 copayment for inpatient admission, then the Plan pays 100% of covered expenses.</p>	<p>Inpatient benefits paid at 80% after deductible, subject to MAC.</p>				
In-Network MHN	Out-of-Network									
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	<p><b>COB Rule</b>—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>
<p><b>Changes, and anticipated changes for 2012 and beyond</b></p>	<ol style="list-style-type: none"> <li>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. As an example, 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. (THIS DOES NOT APPLY TO RETIREES ON THE FUND’S MEDICARE SUPPLEMENT RETIREE PLAN.)</li> <li>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.</li> <li>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.</li> </ol>





## Eligibility

Once you are a retiree, you are no longer eligible for benefits under the Active Plan, unless you again satisfy the active eligibility requirements. To be covered under either Retiree Health Benefits Program, you must apply for coverage, see page 19 for more information. The Fund also charges a “Monthly Retiree Premium” for Program coverage, and the vast majority of individuals pay for this through an assignment of a portion of their pension benefit from the I.U.O.E. Local No. 478 Pension Fund. So, as a general rule, assuming you are eligible, you must elect coverage under one of the Retiree Health Benefits Programs before your Pension Fund benefits begin by this Fund’s application due date. Otherwise, you cannot elect coverage under the Retiree Health Benefits Programs at a later date.

## FAST FACTS

- Under the Plan, there are two programs of Retiree Health Benefits:
  - Pre-Medicare Retiree Benefits Program if you retire at or after age 60 (or earlier if disabled);
- and
- Medicare Supplemental Retiree Benefits Program if you are Medicare-eligible and age 65 or older (or earlier if disabled). Benefits under this Program are secondary to Medicare or any other Health Plan.



Retiree Health Benefits Plan

## Pre-Medicare Retiree Benefits Program

To be eligible for the Pre-Medicare Retiree Benefits Program, you must apply for coverage, meet one of the following rules, and also pay the Monthly Retiree Premium on a timely basis:

- Have been eligible for benefits under the Active Plan at any time with the 12-month period immediately before your initial retirement from one of the pension plans noted below and:
  - Be receiving a pension from the International Union of Operating Engineers Local No. 478 Pension Fund (Pension Fund) that began when you were at least age 60, other than a disability pension from the Pension Fund; or
  - Be receiving a pension from the Officers and Employees of Local No. 478 and Funds' Employees Pension Fund (Staff Fund) that began at or after your normal retirement age, as defined in the Staff Fund's plan document;

or

- Have had contributions received by the Fund on your behalf for at least 9,000 hours in the 120 months immediately before your enrollment in the Pre-Medicare Retiree Benefits Program, and meet any one of the following requirements:
  - Be receiving a pension benefit from a Contributing Employer's qualified retirement plan which initially began at or after the time you had attained age 60, or
  - Have received a pension benefit from a Contributing Employer's qualified retirement plan which initially began at or after the time you had attained age 60, or

## *Retired Members are eligible for:*

- **Medical benefits;**
- **Prescription drug benefits;**
- **Dental benefits;**
- **Vision benefits; and**
- **Death benefit**

- Be eligible to receive a pension benefit from a Contributing Employer’s qualified retirement plan, have attained at least age 60, and have not yet received any of those benefits;

or

- Be receiving a disability pension from the Pension Fund, and must have been eligible for coverage under the Active Plan within the 24-month period immediately before the date you were initially eligible to receive such disability pension.

## Medicare Supplemental Retiree Benefits Program

To be eligible for the Medicare Supplemental Retiree Benefits Program, you must be eligible for Medicare coverage, apply for coverage, meet one of the following rules, and also pay the Monthly Retiree Premium on a timely basis:

- Be receiving a pension from the International Union of Operating Engineers Local No. 478 Pension Fund that began when you were at least age 60;

or

- Be receiving a pension from the Office and Employees of Local No. 478 and Funds’ Employees Pension Fund that began that began at or after your normal retirement age, as defined in the Officers and Employees of Local No. 478 and Funds’ Employees Pension Plan, and have been eligible for coverage under the Active Plan with the 12-month period immediately before retirement;

or

- Have been covered by the Pre-Medicare Retiree Benefits Program, or meet all of the following requirements:

- Be receiving, or have received, a pension benefit from a Contributing Employer’s qualified retirement plan,

- Provide proof to the Fund that at the time he or she initially began receiving, or received, such pension benefit that he or she qualified for a Social Security Disability Award, and that such Award is in place at the time of submission of his or her completed application to the Medicare Supplemental Retiree Benefits Program, and

- Must have been eligible for coverage under the Active Plan within the 24-month period immediately before the date you submit your completed application to the Medicare Supplemental Retiree Benefits Program;

or

- Have had contributions received by the Fund on your behalf for at least 9,000 hours in the last 120 months immediately before your enrollment in the Medicare Supplemental Retiree Benefits Program, and meet any one of the following requirements:

- Be receiving a pension benefit from a Contributing Employer’s qualified retirement plan which initially began at or after the time you had attained age 65, or

- Have received a pension benefit from a Contributing Employer’s qualified retirement plan which initially began at or after the time you had attained age 65, or

- Be eligible to receive a pension benefit from a Contributing Employer’s qualified retirement plan, have attained at least age 65, and have not yet received any of those benefits.

## Special Eligibility Rule for Both Programs

Some individuals retired too early (usually prior to age 60) to obtain coverage under either Retiree Health Benefits Programs, and a number of years ago the Fund’s Trustees established a special rule to deal with this issue. To qualify under this special rule, you would have to return to work in Covered Employment (what we call Post-Retirement Work) after your initial retirement, meet all of the requirements noted below, and then retire again (what we call “Re-Retirement”). Here are all the applicable requirements:

- Considering only Post-Retirement Work, you must earn at least five Years of Vesting Service or five Pension Credits under the Pension Fund, five Years of Vesting Service under the Staff Fund, or five years of service under a Contributing Employer’s qualified retirement plan (in all situations, you would have to earn such years of vesting service or pension credit under the standard rules of the applicable retirement plan, meaning we would disregard any special rules which automatically award years of vesting service or pension credits), and
- You must not have engaged in any Non-Covered Employment at any time during your entire working career, and
- Contributions to this Plan must be made for all of your Post-Retirement Work, and you must have been eligible for Active Plan coverage within the 12-month period immediately before your Re-Retirement, and

- You must prove that you do not intend to perform any Covered or Non-Covered Employment after your Re-Retirement date, and
- At the time of your Re-Retirement, to qualify for: (i) the Pre-Medicare Retiree Benefits Program, you must be at least age 60, or normal retirement age as defined in the Staff Fund’s plan document, or (ii) the Medicare Supplemental Retiree Benefits Program, you must be at least age 65.

Assuming you met the above requirements, you could then apply for coverage under the applicable Retiree Health Benefits Program at the time of your Re-Retirement. You would also have to pay the applicable Monthly Retiree Premium on a timely basis.

## Monthly Retiree Premium

The Fund assesses a monthly charge—known as a Monthly Retiree Premium—for an Eligible Individual’s coverage under either of the Retiree Health Benefits Programs. The applicable Monthly Retiree Premium per Eligible Individual is:

For the Pre-Medicare Retiree Benefits Program:	\$200
For the Medicare Supplemental Retiree Benefits Program:	\$125

As a simple example, if you were eligible for, and properly elected coverage under, the Pre-Medicare Retiree Benefits Program for you and your Spouse, your Monthly Retiree Premium would be \$400 (2 Eligible Individuals x \$200). If you also elected to cover an Eligible Child of yours, your Monthly Retiree Premium would be \$600 (3 Eligible Individuals x \$200).



***Please be aware that the Monthly Retiree Premium is subject to change in the future.***

Also, the Monthly Retiree Premium is a ***distinct payment*** from any monthly payments due for COBRA Continuation Coverage, so please do not confuse them.

## When Coverage Begins

Coverage begins the first day of the month coinciding with or next following the day you satisfy the above requirements.

## Dependent Eligibility

**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.**

While you are eligible, Eligible Dependents can 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;

- Children who you or your 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;

**The Trustees require proof of status as a Spouse or Child, including birth certificates, marriage certificates, adoption decrees, paternity/maternity documentation, and divorce decrees.**

- 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 dependent Child reaches age 19. If you do 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 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 provides coverage to a child over age 26 who is incapable of sustaining self-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.
- A Child over age 26 who is incapable of self-sustaining employment because of a physical or mental disability, provided:
    - 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.

### **When Dependent Coverage Begins**

Assuming you elect coverage for your Eligible Dependents and pay the applicable Monthly Retiree Premium on a timely basis, as described in the next Section, coverage for them will begin on the same date your eligibility begins, or if applicable, a later date, such as the date you acquire a new Eligible Dependent and properly notify the Fund Office, or as specified in a Qualified Medical Child Support Order which has been provided to the Fund Office.

### **Important Rule with All Retiree Health Benefits Plan Coverage—“Choose It or Lose It”**

The basic rule of this Plan is that when you are **first eligible** to apply for coverage (more on this starting on page 19), you must elect coverage for yourself and those Eligible Dependents who you wish to cover. If you do not elect coverage for yourself, you will **never** be able to elect coverage for yourself **or** any of your family members who would otherwise be Eligible Dependents. Similarly, if you elect coverage for yourself, but not for one or more of your Eligible Dependents, you will **never** be able to elect coverage for those Eligible Dependent(s) for whom you declined coverage. This is known as the “Choose It or Lose It” rule. ***So, if you are declining coverage for yourself, or any of your Eligible Dependents, please keep this extremely important rule in mind.***

There are, however, three important exceptions to the Choose It or Lose It rule:

1. If one or more of your Eligible Dependents has coverage under the Active Plan or another plan providing health coverage (what we call “Other Coverage”) at the time you are required to apply for coverage with us, and you provide proof of that coverage to the Fund Office,

then for those Eligible Dependent(s) who have Other Coverage you may defer making an election for such Eligible Dependent(s). Assuming you elect coverage under the Retiree Health Benefits Plan and maintain your coverage until the time your Eligible Dependent(s) loses the Other Coverage, you will be allowed to make an election to cover them at that time. To take advantage of this exception, the Fund Office ***must be notified within thirty (30) days of the loss of Other Coverage.***

**EXAMPLE**

***You elect coverage for yourself only under the Pre-Medicare Retiree Benefits Program on July 1, 2011, and while doing so you provide proof to the Fund Office that your Spouse, Jane, has Other Coverage through her employer. You still have Pre-Medicare Retiree Benefits Program coverage when Jane loses her Other Coverage on June 30, 2012, and you notify the Fund Office of that fact on July 6, 2012. You are permitted to add Jane to your coverage, subject to paying an additional Monthly Retiree Premium per month (which is currently \$200).***

2. Similar to the exception in 1, above, if you are covered under the Retiree Health Benefits Plan and one or more of your Eligible Dependents have provided proper and timely proof to the Fund Office that they have Other Coverage in effect, you may make a one-time irrevocable election to cover such an Eligible Dependent under this Fund ***even though their Other Coverage has not yet ended.*** We must stress that this is a one-time election which cannot be modified at a later time.

**EXAMPLE**

***You elect coverage for yourself only under the Pre-Medicare Retiree Benefits Program on November 1, 2011, and while doing so you provide proof to the Fund Office that your Spouse, Mary, has Other Coverage through her employer. While still covered***

***by the Pre-Medicare Retiree Benefits Program, and while Mary still has coverage through her employer, you notify the Fund Office on August 1, 2012 that you would like to add Mary to your coverage. The Fund will permit you to do this, subject to paying an additional Monthly Retiree Premium per month (which is currently \$200). You cannot change this election in the future, and while Mary is covered under her employer's plan she will have "secondary" coverage under this Fund. See page 73 for more information on "Coordination of Benefits."***

3. If you are covered under the Retiree Health Benefits Plan, it is also possible that you may add a new Eligible Dependent to your family through marriage, birth or adoption. In order to be able to take advantage of this exception and add your new Eligible Dependent(s) to your coverage (known under the law as a "special enrollment period"), the Fund Office must be notified within thirty (30) days of the birth, marriage or adoption.

**EXAMPLE**

***You are single and you elect coverage for yourself under the Pre-Medicare Retiree Benefits Program on July 1, 2011. While still covered by that Program, you get married to Linda on August 1, 2012, and Linda also has a 25 year old son James from a prior marriage who does not have any health coverage. You notify the Fund of the marriage on August 14, 2012. You are permitted to add Linda and/or James to your coverage due to the marriage, subject to paying an additional Monthly Retiree Premium per month (if you choose to cover only Linda or only James) or two additional Monthly Retiree Premiums per month (if you choose to cover both Linda and James).***

To be clear, under all of the exceptions, you must pay the applicable Monthly Retiree Premium for the Eligible Dependent(s) who are being added to your coverage under the Plan on a timely basis. As noted earlier, the Monthly Retiree Premium is subject to change.

## Applying For Coverage

In order to be covered under the Retiree Health Benefits Plan, you **must** apply for coverage for yourself and your Eligible Dependents on a timely basis. Here are the basic rules, assuming you are eligible as outlined earlier:

1. If you are eligible to receive a pension from the International Union of Operating Engineers Local No. 478 Pension Fund (Pension Fund) **or** the Officers and Employees of Local No. 478 and Funds' Employees Pension Fund (Staff Fund), then you must submit a properly completed application form for the Pre-Medicare Retiree Benefits or the Medicare Supplemental Benefits Programs to the Fund Office **before your pension benefits initially begin**. A grace period of up to 15 days may be granted in certain circumstances. Your Monthly Retiree Premium will automatically be deducted from your pension check, and you will be required to sign an authorization form permitting the deduction.
2. If you are eligible to receive a pension from a Contributing Employer **and** NOT from the Pension Fund or Staff Fund, you must first request an application from the Fund Office at least **30 days** before your pension benefits initially begin. Then, your completed application must be submitted to the Fund Office **within 30 days** after the application is mailed to you. Because the Fund Office is not able to set up the automatic deduction process as noted in 1., above, **you are responsible** to submit your Monthly Retiree Premium to the Fund Office by the first day of each month that coverage is provided. In certain circumstances, the Trustees may grant a grace period not to extend beyond the last day of the month that coverage is provided.

If you do not meet these rules regarding a timely application, you will not be eligible for coverage under the Retiree Health Benefits Plan and you will not be permitted to elect it at a future time.

## Continuing Eligibility

Subject to the "When Eligibility Ends" rules discussed immediately below, your eligibility under the applicable Retiree Health Benefits Program will normally continue on a month-to-month basis as long as the Monthly Retiree Premium is received on your behalf on a timely basis. Also, if you return to work as an active employee and you become eligible for coverage under the Active Plan, you will lose your Retiree Health Benefits Program coverage, but you will become eligible for Active Plan coverage. When you lose coverage under the Active Plan, you will be permitted to again elect coverage under the Retiree Health Benefits Plan, assuming you make a new election and submit your Monthly Retiree Premiums in a timely manner.

## When Eligibility Ends

The rules as to when eligibility ends are discussed below. When your coverage ends, you 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 Retirees

Coverage ends on the earliest of the following:

- The date you die;

- For coverage under the Pre-Medicare Retiree Benefits Program, the date you become eligible for Medicare (when you become eligible for Medicare, you must apply for coverage under the Medical Supplemental Retiree Benefits Program to continue coverage);
- The date the Plan terminates;
- The date your Monthly Retiree Premium is not received on a timely basis by the Fund Office;
- 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 pages 92 and 94);
- 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 date you are eligible for coverage under the Active Plan.

In certain situations when your coverage ends, you may be eligible for COBRA continuation coverage as described on page 30. Also, if your eligibility under the Pre-Medicare Retiree Benefits Program ends because you become eligible for Medicare, your Spouse and Eligible Dependents will continue to be eligible for benefits under the Pre-Medicare Retiree Benefits Program until your Spouse or Eligible Dependents become eligible for Medicare, provided the applicable Monthly Retiree Premium payment is made.

### **For Your Dependents**

Your Eligible Dependent's coverage will end on the earliest of:

- The date your eligibility under the Plan ends under any of the rules noted directly above;
- The last day of the month in which your Eligible Dependent engages in either work in Non-Covered Employment or conduct which constitutes a Termination for Cause (see pages 92 and 94);
- The date your Eligible Dependent becomes a Member;
- For coverage under the Pre-Medicare Retiree Benefits Program, the date your Eligible Dependent becomes eligible for Medicare (when your Eligible Dependent becomes eligible for Medicare, he or she must apply for coverage under the Medical Supplemental Retiree Benefits Program to continue coverage);
- As of the point in time that your Eligible 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 date your Eligible Dependent no longer meets the Plan's definition of an Eligible Dependent.

If your Eligible Dependent's coverage ends, your Eligible Dependent may be eligible for COBRA continuation coverage as described 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.
- If your life event results in a loss of coverage, you and/or your dependents may be eligible for COBRA Continuation Coverage.
- Your spouse or beneficiary should contact the Fund Office in the event of your death.



Retiree Health Benefits Plan



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 a Retiree.

***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.**

## 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 30 days of the marriage. Once the timely notice is received and the Fund Office receives the required information (see note above), 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 benefits.

If your Spouse is covered under another group medical plan, you should inform the Fund Office of such other coverage. This will permit you to defer coverage for your Spouse under this Plan until such time that he or she loses that other coverage. Once that other coverage is lost, you can elect coverage for your Spouse under this Plan, but you must notify the Fund within 30 days of the loss of such other coverage. You also have the option to make a one-time irrevocable

election to cover your Spouse under this Plan (see pages 23 and 24 for more details on both options). Whenever you add your Spouse to coverage under this Plan, you will be required to pay the applicable Monthly Retiree Premium on his or her behalf.

## Adding a Child

When you properly add an Eligible Child to your coverage, whether at the time of your retirement 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 below 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, the Child must meet the Plan's Dependent Eligibility rules (see page 22).

***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.**

***IMPORTANT NOTES***

***Under federal law, the two life events noted above generally 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 benefits.

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 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.

***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 Spouse wants to continue coverage, he or she must:***

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

***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.

***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 certified copy of your death certificate.**
- **Apply for your death benefits.**
- **If your dependents want to continue coverage under the Plan, enroll for COBRA continuation coverage.**

## In the Event of Your Death

If you are a Retiree and eligible for coverage on the date of your death, your beneficiary is eligible to receive a Death benefit. A claim must be filed by your beneficiary within 24 months from the date of death. See page 61 for much more information about Death benefits.

Also, if your Spouse and/or Eligible Dependents are covered under the Pre-Medicare Medical

Benefits Program at the time of your death, they may continue their coverage under that Program by paying the necessary Monthly Retiree Premium on a timely basis (see righthand side). If your Spouse or Eligible Dependents later become eligible for the Medicare Supplemental Retiree Benefits Program, they may continue coverage under that Program by paying the necessary Monthly Retiree Premium on a timely basis. Similarly, if your Spouse and/or Eligible Dependents are covered under the Medicare Supplemental Retiree Benefits Program at the time of your death, they may continue their coverage under that Program by paying the necessary Monthly Retiree Premium on a timely basis.

Also, if your Spouse was not covered at the time of your death solely because he or she had “Other Coverage” (see page 23 under the “Choose It or Lose It” rule), and had maintained such coverage until your death, then your Spouse may make an election for himself or herself, and any Eligible Dependent(s), under the applicable Retiree Program *provided*: (1) he or she applies for such coverage within sixty 60 days of your death, (2) provides any required proof or documentation to the Fund Office, and (3) pays the necessary Monthly Retiree Premium on a timely basis.

**When COBRA continuation coverage ends, you will be provided with a Certificate of Creditable coverage showing the 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.**

## 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 Plan Administrator.

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 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 behavioral health benefits. **Please be aware that COBRA coverage does not include Death benefits.** See page 51 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 dependents (including both the Fund’s share and the dependent’s share, if any) plus an additional 2%. If the 18-month period of COBRA continuation is extended because of disability, the Fund is permitted to charge the full cost of coverage for similarly situated dependents (including both the Fund’s share and dependent’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

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

- Your Spouse dies;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both). Your Spouse becoming entitled to Medicare means that your Spouse: 1) was eligible for Medicare benefits and 2) enrolled in Medicare (under Part A, Part B or both); or
- You become divorced or legally separated from your Spouse.

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

- You die;
- You become entitled in Medicare benefits; 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 coverage ends for any of the above reasons. Notices will be sent to such a child in care of the custodial parent.

If a Retiree should enter service in the Uniformed Services as defined by the Uniformed Services Employment and Reemployment Rights Act (USERRA) for at least 30 days, the service may be considered a qualifying event under COBRA. If you are eligible for COBRA, you, along with

your Eligible Dependents, would be able to elect to make self-payments for COBRA coverage, regardless of any coverage provided by the military or government. You may also be entitled to the reinstatement of coverage upon your return from service. ***Be sure to notify the Fund Office if you should enter military service.***

#### ***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 Retiree 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, but NOT ALL***

While the Fund Office is normally notified of a retiree's death (via the Retiree's family) or a retiree 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 a Retiree's death or a Retiree becoming 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 Retiree 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 Plan  
1965 Dixwell Avenue  
Hamden, CT 06514-2400***

***Tel: (203) 288-9261 or  
(866) 288-9261 (toll free), using 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. In situations involving a loss of employment or a reduction of hours, COBRA continuation coverage could normally last for up to 18 months. Since this booklet deals exclusively with benefits available to Retirees, we believe the maximum 18 month COBRA period will rarely, if ever, come up.

However, when the qualifying event is 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. The Fund Office sees these situations commonly in the Retiree Programs.

In addition, there are two other ways in which the 18-month COBRA continuation coverage period mentioned above can be extended. Again, these will likely be rare in our Retiree Programs, but they are explained in the very next sections.

### **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. 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. To qualify, the Fund Office must be provided with a copy of the SSA's written determination of disability within 60 days after the date of such written determination was issued *and* 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 5.

### **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, 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 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 5.

### **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 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 within 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](http://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.

**Returning to Work**

If your eligibility ends because you return to work in Covered Employment after you retire, you can become eligible for the Retiree Health Benefits Plan again by meeting the eligibility requirements as described on page 19.



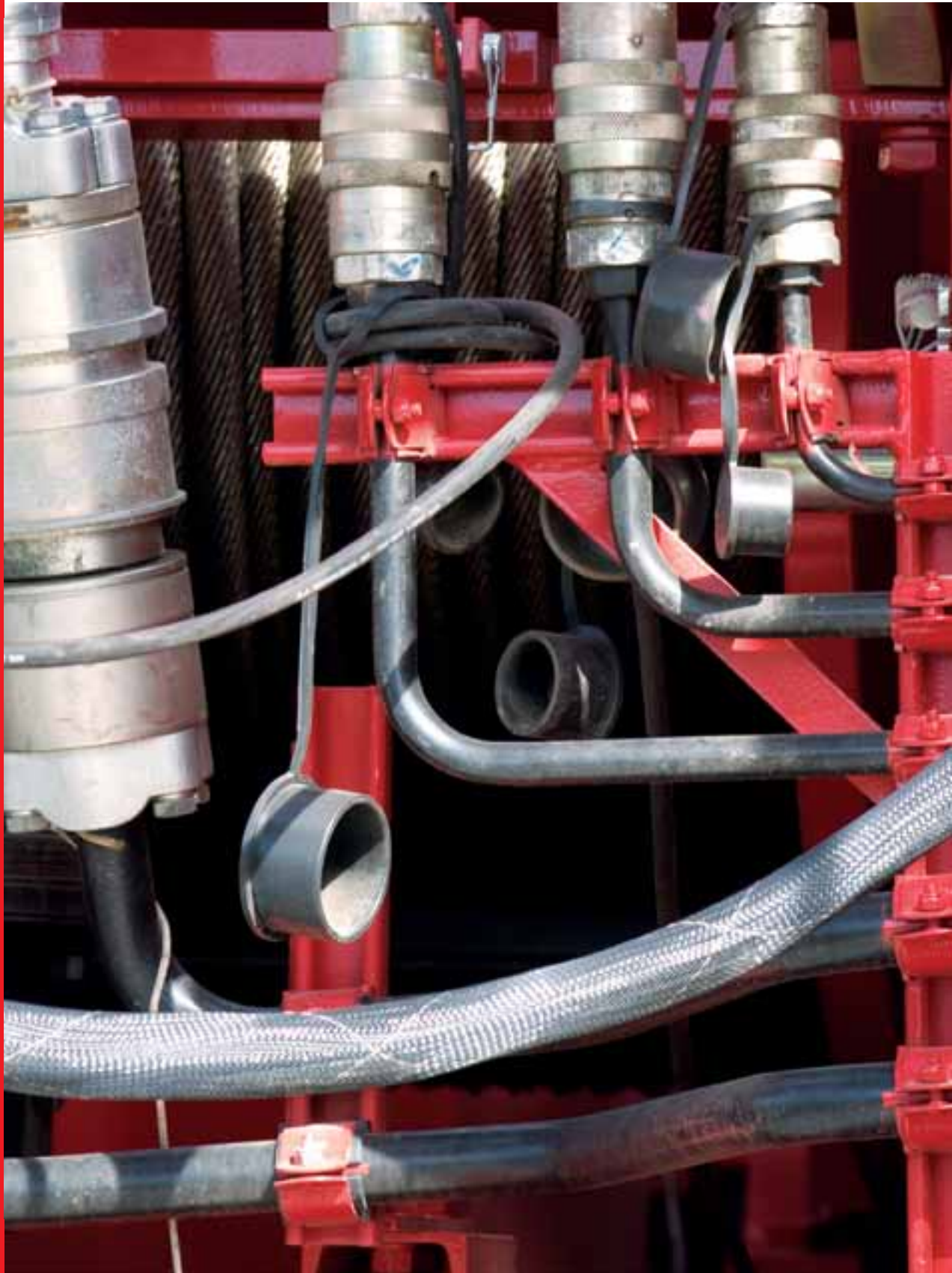


## Medical Benefits

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)—for Eligible Individuals in the Pre-Medicare Retiree Benefits Program**

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. *However, under the Medicare Supplemental Retiree Benefits Program, claims are discounted for Medicare rates; therefore, the Fund cannot apply PPO discounts to claims under this Program.*

### **You Must Show Your ID Card Each Time You Receive Medical Care.**

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.

### **For Eligible Individuals in the Medicare Supplemental Retiree Benefits Program**

For those Eligible Individuals covered by Medicare, the Fund Office will provide you with a Medicare Supplemental Retiree Benefits Program identification card, which you should show to your provider whenever you utilize medical services. As a general rule, the Plan will be secondary to Medicare, unless the Plan’s “Coordination of Benefits” rules come into play (see page 73 for more details). Under normal circumstances, Medicare will process the claim and issue a Medicare Explanation of Benefits statement, and your provider will send along the

### ***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.**

### ***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 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.**

statement and a paper claim to the Fund as well. Assuming the Fund has the information it needs and the services provided are otherwise covered under the Plan's rules, **we will process the balance of the claim at 90%**. No deductibles apply to secondary claims paid by the Fund, and copayments will not apply for Eligible Individuals who are covered on a primary basis by Medicare EXCEPT for purchases of prescription drugs. If you have any questions, you may always contact the Fund Office!

**Deductible (Out-of-Network Only) (Does not apply to the Retiree Program)**

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 deductible before the Plan begins to pay benefits for non-PPO provider services.

The deductible applies to each eligible individual 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 covered members of 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.

***If you NEED to be Hospitalized:***

**Bring your medical ID card to the Hospital.**

**Coinsurance/Copayment**

For PPO-network services, you are not responsible for meeting a deductible. You simply make your copayment, which is 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, 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 limitation. 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 services from an out-of-network provider the Plan will pay:

- 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 is 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 not normally know of the circumstances surrounding a particular claim unless you inform us.

### **Annual Maximums**

You and each eligible dependent can receive medical benefits up to the annual maximums specified in the "Schedule of Benefits" on page 7. Certain services have separate annual 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 pages 89 and 92 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 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 Retiree 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.***

## **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?*

## **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 up to 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.

## **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 a 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.

### **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 you or an eligible dependent for the same or related injury or illness as a prior surgery are considered a new surgery 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.



***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.**

**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 also 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 Retiree (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 Caesarian 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 entitled to 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 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 for 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 8 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 any 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 routine physical 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 Benefit**

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. 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.

The Plan will pay for the following charges:

- Care in hospice facility or 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 44; 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 does not qualify for the rehabilitative nursing home benefit as described in the Schedule of Benefits on page 7, and has 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 entitled to coverage under the applicable benefits in the Plan. Eligible children are not entitled to this benefit. Mammography’s 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 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 those furnished as the result of a heart or heart/lung human 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.***

### Behavioral Health Benefit

The Plan will pay covered charges for behavioral health services and treatment for you or your eligible dependents up to the limits listed in the Engineers Family Assistance Program or EFAP administered by MHN. The EFAP is not available in the Supplemental Retiree Benefits Program.

Refer to page 16 of the “Schedule of Benefits” for details of covered Behavioral Health Benefits.

### 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 individual’s 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, or 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
- Prostheses 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 “Exclusions” on page 63.
- 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 is 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:
<b>Prescription Type</b>	
Generic	Lesser of drug cost or \$15
Brand (Formulary)	Lesser of drug cost or \$30
Brand (Non-Formulary)	Lesser of drug cost or \$45

***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.***

**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.**

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%.

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

## When You Fill Prescriptions Through the CVS/Caremark Mail-Order Program (Maintenance Choice 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 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:
<b>Prescription Type</b>	
<b>Generic</b>	Lesser of drug cost or \$25
<b>Brand (Formulary)</b>	Lesser of drug cost or \$55
<b>Brand (Non-Formulary)</b>	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 the 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 contract number for the specialty pharmacy 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.

### ***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.**

## Generic Equivalents and Brand Name Medications (Generic Step Therapy Program)

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 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.

### **EXAMPLE**

***Lisa takes a medication that costs \$100 for a brand name drug 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:

- a. Urinary antispasmodics
- b. HMG (CoA Reductase Inhibitors-Lipid lowering agents)
- c. ACE Inhibitors - ARB (Angiotensin II blockers)
- d. Nasal steroids
- e. Bisphosphonates
- f. Sleep aids
- g. Cox-2 inhibitors (Non-steroidal anti-inflammatory drugs)
- h. Triptans
- i. SABA (Short Acting Beta Agonists)
- j. NSA (Non-sedating Antihistamines)
- k. SRRI (Selective Serotonin Reuptake Inhibitors)
- l. 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.

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 eligible individuals over age 26);
- All injectable prescriptions, including those used for contraception;
- Dexedrine;
- Rebetron;
- Viagra, Cialis, Levitra and similar drugs (**only** for a male Retiree, or the Spouse of a female Retiree) 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, cyro), 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 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 Xenical, provided that you follow any applicable procedures of the Fund and CVS/Caremark.

## Prescription Drug Expenses Not Covered

In addition to the “General Plan Exclusions” on page 53, 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 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 63;
- Laetrile; and
- Smoking deterrents or weight control medications except as listed on pages 53.





# 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.



Retiree Health Benefits Plan

When you or a covered family member 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 **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, if covered, 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, up to the applicable maximum for a Plan Year, as shown in the “Schedule of Benefits” on page 7.

## 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; 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;
  - 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.

***Denture replacement will be paid once every five (5) calendar years.***

## 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 in 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 56 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 63), 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" for changes in your or your eligible dependents' vision due to surgery. 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 dependents who are covered under another vision plan that is the primary payor.

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

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/frame collection.

A Retiree is eligible for a second pair of glasses. The second pair of glasses may be clear prescription glasses, prescription sunglasses, or bifocal sunglasses. Your Spouse may receive two pairs of glasses in lieu of bifocals, otherwise, one pair (of non-bifocal glasses). Your Spouse may elect only one pair of premier frames or photo-grey extra lenses, or one pair of progressive lenses. As mentioned earlier, eligible children under age 13 as of the first day of the Plan Year (i.e., January 1st) may obtain one pair of glasses every year, while eligible children age 13 or above can obtain one pair of glasses every other year.

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

## Vision Services Not Covered

In addition to the “Exclusions” on page 63, 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 59;
- 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 53; and
- Replacement of lost or damaged contact lenses.



## Death Benefits

Death benefits are paid if a Retiree dies 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.

## FAST FACTS

- Consult the Schedule of Benefits to see your death benefit amount. Generally benefits are paid in one lump sum.
- Your beneficiary must provide the Fund Office with a certified copy of your death certificate in order to receive a benefit.
- If you lose coverage for another reason besides death, your life insurance will terminate.



Retiree Health Benefits Plan

## Death Benefits (Retirees Only)

The spouse or beneficiary must notify the Fund immediately upon the death of the Retiree. 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, Retiree's death certificate (certified copy), etc.) before the Death benefit can be paid.

Death (Life Insurance) claims must be filed no later than two years from the date of death.

### **Benefit Amount**

The amount of the benefit is shown in the "Schedule of Benefits" on page 7. 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 Retirees Who Lose Coverage**

A Retiree can lose coverage under the Plan for a reason other than death. When such coverage is lost, the Retiree'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 call a "conversion right."

***If a former Retiree 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 Retiree 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 Retiree 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.

Here is the address and telephone number for Reliance:

***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 Retiree 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.

## Naming a Beneficiary

You may designate anyone you wish as your Beneficiary for Death (Life Insurance) 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.

**A Beneficiary is the person or persons shown in the Plan's records that you designate to receive your death benefits.**



# Exclusions







## 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:

1. 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.
2. Employment-related injuries or illnesses covered by a workers' compensation act or similar legislation, except:
  - As otherwise payable under Death 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; and
  - 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.
3. 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.
4. Injuries or illnesses caused by war or any act of war, declared or undeclared.
5. Injuries or illnesses incurred while on active duty in any branch of the armed services of any country.
6. Charges for Experimental Procedures.
7. Charges for routine physical examinations, except those that are covered under the Plan.
8. 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 payor primary to this Plan, but for you or your dependent's failure to follow rules and restrictions of the primary payor.
9. Charges payable by a third party, except as permitted under the Plan.
10. 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.
11. Charges for services beyond the scope of the license of the person performing them.
12. Charges for cosmetic surgery or treatment, except those specifically covered under the Plan.

13. 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 feet or of any metatarsalgia or bunion (except for charges for an open-cutting operation).
14. 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.
15. 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.
16. 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.
17. Examination of the eyes for eyeglasses, except as covered under the vision benefit.
18. Outpatient medications and drugs, except as covered under the prescription drug benefit.
19. Private duty nursing for a nurse rendered while hospitalized.
20. 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.
21. Claims for medical benefits received by the Fund Office more than two years after the date services are rendered.
22. Claims for Death 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.
23. Charges for injuries or Illness incurred while engaged in Non-Covered Employment.
24. Charges for complications in connection with a non-covered service.
25. Charges for surgical or medical abortion other than:
  - Medical complications that arise for a Retiree or the Retiree’s Spouse;
  - When the mother (a Retiree or the Retiree’s Spouse) would be endangered if the fetus were carried to term; or
  - Spontaneous non-elective abortion incurred by a Retiree or the Retiree’s Spouse.
26. Charges related to abortion, pregnancy, or infertility treatment or procedures of an eligible child, except those described in the Pregnancy Benefit on page 41.



# Claims and Appeals



## How to File Claims

**Claims should be filed within two years of the date services are received or the claims incurred, or your claim may be denied.**

### **Medical Claims – Eligible Individuals in the Pre-Medicare Retiree Benefits Program**

If you or an eligible dependent has coverage under more than one health care plan, benefits are coordinated (see page 73).

With each claim, 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.

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 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 number 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***

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

### **Medical Claims – Eligible Individuals in the Medicare Supplemental Retiree Benefits Program**

If you are on Medicare (because you are age 65 or older, or on a Social Security Disability), you will receive the Fund's Medicare Supplement Identification card. Whenever you utilize medical services, show this card to your doctor, hospital, lab, or other provider. ***Your claim will be submitted directly to the Fund via a paper claim, usually by the provider of service.***

The Fund must receive the itemized bill and the corresponding Medicare Explanation of Benefits statement showing payment or denial of services.

**The Fund will then process the balance of the claim at 90%. No deductibles will be applied to these secondary claims.**

### **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**

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.***

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

### **Certain Prescription Drug and Vision Claims; Death Benefit Claims**

If you incur a prescription drug claim from a pharmacist who is not part of the CVS/Caremark network or a vision care provider who is not part of the Davis Vision network, you should write or call the Fund Office.

If a beneficiary needs to file a Death benefit claim due to a Retiree's death, the beneficiary should contact the Fund Office immediately. Written

proof of the Retiree's death (a death certificate) must be provided to the Fund Office, along with any required application materials. As noted on page 61, the Fund's Death benefit is provided through an insurance company (Reliance), so while we work as quickly as we can, Reliance ultimately issues the benefit check. A Death benefit claim must be properly filed within two (2) years of a Retiree's death or it will be denied.

Send claims for prescription and vision (if incurred with out-of-network providers), and Death benefit 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 a Retiree or eligible dependent or by someone authorized to act on behalf of the Retiree 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—  
INJURY-RELATED CLAIMS**

*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 73).***

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.

**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 “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;
- Pre-service claims – 15 days;
- Urgent care claims – 72 hours;
- Death 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 Further Information Is Needed***

If further information is needed from the claimant, the doctor or the provider, the necessary information or material will be requested in writing. The request for such information will be sent within the normal time limits shown above, except that any further 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;
- Pre-service claims – 15 days;
- Death 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 criteria to make its decision, the notice will state that the specific internal rule, guideline, protocol, or criteria 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 written 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 claims, the applicable time period is 60 days. The notice of appeal is considered to have been filed on the date it 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, 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 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 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 extension 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 (120) days 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 Death 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 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 Death 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 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). In the event both you and a dependent are covered under different group health plans as 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 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 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 same 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 28) 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:

- Eligible dependents age 65 or older or who are entitled to Medicare benefits because of their age; or
- Eligible 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.

### **Medicare Supplemental Retiree Benefits Program-Coordination of Benefits**

If you are covered under another health plan, the Medicare Supplemental Retiree Benefits Program will pay third to the health plan (primary payer)

and to Medicare (secondary payer). If you are not covered under another health plan, the Medicare Supplemental Retiree Benefits Program will pay secondary to Medicare. If your Spouse or Eligible Dependents are covered under another health plan, the Medicare Supplemental Retiree Benefits Program will pay second to that health plan (primary payer). Where the Spouse or Eligible Dependents are also covered under Medicare, the Plan will pay third to the health plan (primary payer) and to Medicare (secondary payer).

Claims under the Medicare Supplemental Retiree Benefits Program are discounted to reflect Medicare rates, therefore, PPO discounts are not applied to claims under this Program.

## Medicare Information

**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.**

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 800-MEDICARE (633-4227).

### **A Bit More Information About Medicare Part D**

As noted above, Medicare Part D is Medicare's prescription drug program. Please be aware that our Fund currently provides prescription drug coverage (through CVS/Caremark, as discussed in more detail on pages 49 through 54) to Eligible Individuals who are entitled to Medicare. In addition, our Fund prescription drug coverage is "creditable," which means that our Fund is expected to pay out at least as much as the standard Medicare Part D plan. In plain terms, this means that if you are covered by the Fund and entitled to Medicare Part D benefits, you do not have to enroll in Medicare Part D and you can instead receive your prescription drug benefits through the Fund. On an annual basis, the Fund will issue a notice informing you of whether the Fund's prescription drug coverage is creditable. You should keep copies of these notices in the event you need them at a future time.

***If you are covered by the Fund, entitled to Medicare, and you choose to obtain Medicare Part D coverage, you cannot also use the Fund's prescription drug coverage.*** Please be aware that you will lose your Fund prescription drug coverage as of the date of your eligibility in the Medicare Part D program. If you elect Medicare Part D coverage and later determine that you wish to cancel your Medicare Part D coverage and re-enroll in the Fund's prescription drug coverage, you will be given a once-in-a-lifetime opportunity to do so. You must write to the Fund Office and indicate the future date you wish your Fund prescription drug coverage to resume, and you must also provide various information to the Fund Office, including: (1) proof that you maintained your Medicare Part D coverage continuously, and (2) a copy of your Medicare Part D disenrollment notice.

## Reimbursement

The Fund is not liable for any health expenses or costs (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, has signed a reimbursement agreement, if Expenses are paid 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 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 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 dependents by the Connecticut Victim’s Fund are not subject to the Plan’s reimbursement rules.

## Other Reimbursements

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 Federal Health Care Reform 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 anyone 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 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  
***The 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. Trustees of this Plan as of the printing of this booklet are:

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

**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 also 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 on page 5.

**Source of Contributions**

Retiree contributions and dependent contributions (through the Monthly Retiree Premium), COBRA self-payments, and other self-payments 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) through an arrangement with an insurer, currently Reliance Standard.

The Plan also receives Employer contributions with respect to active Employees, and such contributions 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, death 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 retiree eligibility, as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits, are described fully in this booklet.

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 or capricious.

**Claim Procedure**

The procedures to follow for filing a claim for benefits are listed on pages 65-71 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 Retiree 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 employee 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 Union or any other person, may

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](http://www.dol.gov/ebsa)**.





# Definitions



Retiree Health Benefits Plan

**Beneficiary** means a person named to receive Death benefits under this Plan because of that person's designation for the benefits by a Retiree.

**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 Retiree. A stepchild is a child from a former marriage or a Retiree's Spouse, and a child is considered "lawfully adopted" if he or she is legally adopted by, or lawfully placed for adoption with, a Retiree. If a Retiree's Spouse has a child out of wedlock prior to the Spouse's marriage to the Retiree, 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/Retiree 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 10% or 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, Retirees or other Employees. The term also includes, subject to the approval of the Trustees, the Union or an employee benefit Fund 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 pay in a Plan Year before you or they would be entitled to benefits. 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 Retiree.

**Eligible Dependent** means any of the following individuals, *provided* that such Retiree has both properly and timely elected Fund coverage for the applicable individual(s) *and* has timely paid all required Monthly Retiree Premiums for the applicable individual(s):

- The Retiree's Spouse;
- The Retiree'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 Retiree'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 Retiree while the Retiree had coverage, regardless of the Child's age, provided that the Child was both: (i) dependent on the Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree must provide applicable proof to the Fund Office.

- The Plan provides coverage for a Child of a Retiree while the Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree must provide applicable proof to the Fund Office.

**NOTE**

*If you are a Retiree 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 Retiree, and any Eligible Dependents of a Retiree.

**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) employed in bargained work by a Contributing Employer; or (5) a person who is a member of a limited

liability corporation with fewer than four members and;

- 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.

**Engineers Family Assistance Program or EFAP** means a professional consultation and referral program established by the Plan, currently managed by MHN, which is designed to direct and monitor the treatment for personal and family problems, mental/nervous disorders and alcohol and substance abuse in connection with the Active Plan of benefits.

**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 Patient Protection and 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.)

In making determinations of “Experimental Procedures,” the Trustees may rely on the advice of the Fund’s Medical and/or Dental Consultant or Consultants.

**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 478 Health Benefits 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 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 a 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:

- 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 hospitals; and
- Has accreditation under one of the programs of the Joint Commission on Accreditation of Health Care Organizations.

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 sickness, disorder, or disease. 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 93).

**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 not 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.

**Monthly Retiree Premium** means the monthly amount a Retiree is required to pay to the Fund on a monthly basis to maintain Retiree Health Benefits Program coverage for himself or herself, along with any Eligible Dependents. Much more information about the Monthly Retiree Premium is found on page 30.

**Non-Covered Employment** means:

- (i) employment in the jurisdiction of 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 office; director; supervisor, stockholder in a similar capacity for the employer, but excludes employment that is performed by an employee of the Union at the exclusive 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 or a related employee benefit fund 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 currently utilizes data provided by New York Medical Management, Inc. and/or Anthem Health Plans, Inc. for out-of-network charges.

**Retiree** means a former Employee who has properly elected coverage under the provisions of the Pre-Medicare Retiree Benefits Program or the Medicare Supplemental Retiree Benefits Program, and maintains his or her Fund eligibility by making any and all Monthly Retiree Premium payments on a timely basis and complying with all applicable Fund rules.

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

**Spouse** means a person to whom a Retiree 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 of 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.

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