# INTERNATIONAL UNION OF PAINTERS AND ALLIED TRADES

# DISTRICT COUNCIL NO. 21

# WELFARE FUND

# SUMMARY PLAN DESCRIPTION

**For Active Participants, Retirees, and Eligible Dependents**
**Covered Under Plans T & X (Glaziers, Painters/Drywall)**

**MAY 1, 2012**

# International Union of Painters and Allied Trades

# District Council No. 21 Welfare Fund

2980 Southampton-Byberry Road

Philadelphia, PA 19154

800-252-7252

215-934-5130

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The Board of Trustees is pleased to provide you with this updated booklet describing the benefits available to you and your eligible dependents under the International Union of Painters and Allied Trades District Council No. 21 Welfare Fund (referred to in this booklet as the "Fund" or the "Plan"). Your benefits may include:

- **hospital and medical coverage** Capital Blue Cross (“Blue Cross”) to provide the PPO program.
- **prescription drug benefits** through Express Scripts, Inc. (“ESI”)
- **dental benefits** through Fidelio Dental Insurance Company (“Fidelio”)
- **vision services** through National Vision Administrators (“NVA”)
- **life insurance coverage (for eligible Active Participants only)** through Amalgamated Insurance Company which pays a benefit to your beneficiary if you die from any cause while covered by the Plan
- **accidental death and dismemberment benefits (for eligible Active Participants only)** through Amalgamated Insurance Company which pay a lump sum to your beneficiary if you die from an accident and a benefit to you in the event of loss of one or more limbs, or your eyesight, due to an accident
- **weekly disability benefits (for eligible Active Participants only)** which pay a weekly benefit if you become temporarily disabled as the result of a non-work related injury or illness

This booklet provides a description, written in everyday language, of plan provisions in effect as of May 1, 2012. Together with the description of benefits provided by Capitol Blue Cross and other providers, it constitutes a summary plan description, or “SPD.” Please keep all of the summaries together in a convenient place, where you will have them for future reference and can share them with your family.

Although these booklets provide essential information about your benefits, this information is intended only as a summary of the terms under which benefits are provided. Additional information concerning your benefits is contained in related documents, such as insurance contracts. This summary plan description together with the insurance contracts are the plan documents pursuant to which benefits are provided. If there is ever a conflict between the summary plan description and the insurance contracts, the applicable insurance contracts will govern.

If you have any questions about the Plan, please contact the Fund Office. For questions on a particular benefit, contact the provider of that benefit. There is contact information for all providers at the back of this summary.

Sincerely,

The Board of Trustees

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# YOUR BENEFITS AT A GLANCE

A summary of your benefits appears below.

**YOUR BENEFITS AT A GLANCE FOR PLANS T & X**
**FOR ACTIVE PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS**

## Hospital and Medical Benefits

**Provided by Capital Blue Cross**

See your summary for more details. Generally, though:

- When you receive **"in-network"** services, there is a $500 per person and $1,500 per family deductible, 10% coinsurance, an unlimited lifetime maximum. There is an out of pocket maximum of $2,000 per person and $6,000 per family then the plan pays 100%.
- When you receive **"out-of-network"** services, you have an annual deductible of $1000 per person and $3,000 per family, thereafter you pay 30% of the Plan Allowance plus the difference between the provider's charge and the Plan Allowance.

## Prescription Drug Benefits

**Provided through Express Scripts: ("ESI")**

- If you go "in network" to a **participating pharmacy**, you have a $20 copay for a generic drug and a $30 copay for a brand name drug and you will receive up to a 30 day supply. Maintenance medications will only be available at the retail pharmacy for a maximum of (2) fills. Thereafter, you must use the mail order service.
- Through the **mail order** service, you have a $40 copay for a generic drug and a $60 copay for a brand name drug and will receive up to a 90 day supply.

If you choose a brand name drug when a generic equivalent is available, you will be required to pay, in addition to the copay, the difference in cost between the generic and brand name drug.

## Dental Benefits

**Provided through Fidelio ("Fidelio"):**

- You have a choice of in-network or out-of-network dentists.
- The Plan has established a maximum allowable charge for each covered service.
- When you receive services **in-network**, the Plan pays a specified percentage of the allowable charge (for example, 80%) and your copay is the remaining percentage (for example, 20%).
- When you go **out-of-network**, the Plan pays the same amount (a specified percentage of the allowable charge) it would pay if you went in-network. You will be responsible for paying 100% of any amount the dentist charges above what the Plan pays.

The Plan provides an annual maximum of $1,500 per covered person for all covered dental services (except orthodontia).

## Vision Benefit

**Provided through National Vision Administrators ("NVA"):**

You may choose an NVA participating provider or another provider of your choosing. The Plan provides vision benefits as follows:

- Age 19 and under, one exam and lenses or contacts every 12 months, frames every 24 months,
- Age 20 and older, one exam and glasses (lenses and frames) or contact lenses every 24 months.

## Weekly Disability Benefits (for Active Participants only)

**Provided through the Fund Office:**
If you become disabled while covered by the Fund, you may be eligible for a weekly disability benefit from the Fund of $350 per week for up to 26 weeks for any one disability. Weekly disability benefits are not paid for job-related injuries or illness.

## Life Insurance and Accidental Death & Dismemberment Benefits (for Active Participants only)

**Provided through Amalgamated Insurance Company ("Amalgamated") and the Fund Office:**

- $30,000 is paid to your beneficiary if you die from any cause while covered by the Fund.
- If you die as the result of an accident, an additional $30,000 is paid to your beneficiary.
- Up to $30,000 may be paid to you if you lose one or more limbs, or your eyesight, as the result of an accident.

## YOUR BENEFITS AT A GLANCE EFFECTIVE NOVEMBER 1, 2008 MEDICARE ELIGIBLE RETIREES AND MEDICARE ELIGIBLE DEPENDENTS UNDER PLANS T & X

If you're eligible for Medicare, the Fund offers "Medigap" coverage..
See the section called "Retiree Benefits" for more information.

# ELIGIBILITY AND PARTICIPATION

## Who Is Eligible To Participate?

You are eligible to participate in the Plan if you are in any of the following categories:

- Active Participants
- Retired employees ("Retirees")
- Eligible Dependents.

**Words that are capitalized in this summary, such as "Active Participant" and "Retiree," are generally defined in the text where they appear.**

## Payment for Coverage

Generally, the benefits under the Plan are available to you free of charge, except for the copays, deductibles and coinsurance that apply to particular benefits, the self-pay rules that may apply to some participants, and any amount due for extended coverage under "COBRA." More information on these features is available in later sections.

### *Patient Protection and Affordable Care Act*

The Board of Trustees believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (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. Being a grandfathered health plan means that your 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 benefits.

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 Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

## Eligibility for Active Participants

You are eligible to participate in this Plan as an Active Participant if you work in "Covered Employment."

**"Covered Employment" means work covered by a collective bargaining agreement or another agreement that requires your employer to make contributions to the Fund on your behalf.**

### When Coverage Starts for Active Participants

If you are an Active Participant, coverage automatically starts after completion of the initial eligibility requirements described below and you contact the Fund Office.

### Requirements for Initial Eligibility

In order to meet the initial eligibility requirements you must complete 500 hours in Covered Employment within a consecutive six month period. Your coverage takes effect on the first day of the month following the date you are credited with 500 hours and will remain in effect for the benefit period in which you became effective and the next benefit period.

### Requirements for Continued Eligibility

In order to maintain eligibility under the Plan, you must work the number of hours outlined according to the following schedule:

**CONTINUING ELIGIBILITY**

| MINIMUM NUMBER OF HOURS WORKED FOR ELIGIBILITY – "PLANS L" | | |
|---|---|---|
| **If you work this many hours…** | **During this work period…** | **Then you are eligible for coverage during the following benefit period…** |
| 700 hours | July 1 – December 31 | April 1 – September 30 |
| 700 hours | January 1 – June 30 | October 1 – March 31 |

### What Happens If You Do Not Work The Required Hours In A Work Period?

If, after establishing your eligibility, you do not meet the hours requirement in a particular work period as outlined above, you may be eligible to continue coverage through the "Look-Back Rule," the "Hours Bank" or through "Self-Payment," as described in the following sections.

**Look-Back Rule**. If you fail to work the required hours in a work period, you can maintain your coverage through the "Look-Back Rule." Under this rule, the Plan "looks back" to see if you worked 1400 hours in the twelve consecutive month period ending with the last day of the work period in which you failed to work the required hours. The following table shows how this works.

| CONTINUING ELIGIBILITY UNDER THE LOOK-BACK RULE | |
|---|---|
| **If you did not meet the hour requirement during the following work period…** | **Then the Fund will "look-back" to see if you met the 1400 hour requirement in preceding 12-month period…** |
| July 1 – December 31 | January 1 – December 31 |
| January 1 – June 30 | July 1 – June 30 |

**The Look-Back Rule is only for maintaining eligibility, NOT for establishing eligibility for the first time.**

**Hours Bank**. Another way to continue eligibility when you do not work the minimum hours and do not qualify for continued coverage under the Look-Back Rule is through the Hours Bank. Under this feature, any hours above 1,800 that you work during a calendar year will be "deposited" in the bank for later use (April 1st of the following calendar year). Hours are deposited at the end of the calendar year in which they are earned. You can use these hours to qualify for up to one Benefit Period per twelve-month period. You may hold a maximum of 6,000 hours in the Hours Bank, and you can use up to 75% of your balance at any one time.

**Forfeiture of hours**. Your Hours Bank balance will be forfeited if:

- you leave Covered Employment and do not re-establish eligibility within 10 benefit periods (five years), or
- you are no longer represented by the "union" for employment purposes (for reasons other than disability or early retirement). The "union" includes District Council No. 21 and any other affiliate of the IUPAT

**Self-Payment**. If you cannot maintain eligibility through either the Look-Back Rule or the Hours Bank, the Self-Pay option allows you to make payments to the Fund to continue your coverage. Under this rule, you may pay for up to 50 hours to qualify for a maximum of one Benefit period per 12-month period.

**You cannot use Self-Payment for initial eligibility or to reestablish eligibility once it has lapsed. The Self-Payment option cannot be combined with the Look-Back Rule or the Hours Bank.**

**You may also be eligible to pay for continued coverage under the Consolidated Omnibus Budget Reconciliation Act, ("COBRA"), which provides extended coverage when your eligibility might otherwise end. For more information on COBRA, see the section called "Continuation of Health Care Coverage Under COBRA."**

**Self-payment rates**. Self-payment rates are set by the Board of Trustees and may be changed from time to time. Generally, the rate depends on the current contribution rate in the collective bargaining agreement. The Fund Office can provide you more information on the current self-pay rates.

The Fund Office must receive your payment before the first day of the Benefit period for which it applies.

### Eligibility for Retirees

The Plan also provides coverage for Retirees. If you retire, your eligibility will continue if you:

- are receiving a normal, early, or disability pension benefit from the IUPAT Pension Plan,
- are currently eligible for Fund benefits on the effective date of your pension, and
- make the required monthly contributions to the Fund.

Depending on whether you are eligible for Medicare and what kind of coverage you elect, your benefits may be different than the standard Plan benefits. For information on benefits for Retirees and their Eligible Dependents, see the section called "Retiree Benefits."

### Dependent Coverage

Coverage for your dependents generally starts at the same time as your coverage, as long as you file an enrollment form in a timely fashion.

**Your dependents will not be covered if you fail to submit an enrollment form.**

### "Eligible Dependents"

Your Eligible Dependents include:

- The spouse to whom you are married.
- Your child or children under twenty-six (26) years of age. In general, coverage will end the first day of the month following the Dependent child's 26th birthday. Until January 1, 2014, if your child could obtain employer-sponsored health coverage (either through your child's employer, or your child's spouse's employer) aside from coverage through a parent, your child will not be eligible for coverage.

**When you enroll a dependent you will be asked to provide proof of dependent status — for example, a birth certificate, a marriage certificate, or other proof of dependent status.**

**New dependents**. If you have a child by birth, adoption, or placement for adoption, your dependent child will be covered from the date of the birth, adoption, or placement, provided you file an application form at the Fund Office within 31 days of the birth/adoption/placement. If you get married, your spouse will be covered starting the first day of the month following the month in which you got married. If you do not complete the application within 31 days from the date of the acquisition, coverage for your dependents will be delayed.

**Dependent children** include your natural children, stepchildren, adopted children, a child placed with you for adoption, and other children required to be recognized under a Qualified Medical Child Support Order ("QMCSO"), who are not married and are wholly dependent on you for financial support.

**About QMCSOs.** A Qualified Medical Child Support Order, or QMCSO, is an order issued by a court or state administrative agency that requires that medical coverage be provided under a plan for a child or children. A QMCSO usually results from a divorce, legal separation or paternity proceeding.

The Fund Office will notify you if a QMCSO is received with regard to your coverage. If you, your child, or the child's custodial parent or legal guardian would like a copy of the Plan's written procedures for handling QMCSOs, or if you have any questions about this process, please contact the Fund Office.

**Except for approved deferrals, Retirees or Dependents of Retirees who do not continuously maintain coverage cannot be added for coverage under the Plan after there is a break in coverage. No new dependents will qualify as dependents under the plan after your initial retirement date except if you defer such dependent coverage by completing the appropriate forms.**

**When Coverage Ends**

**For Active Participants.** Your coverage ends on the first of the following:

- the last day of the last Benefit period for which you qualify for benefits,
- the 31st day of active military duty for the United States or such later date as required by applicable law,

- the date your employment category is no longer covered by a collective bargaining agreement or participation agreement,
- if you stop seeking work on a daily basis with employers who have collective bargaining agreements with IUPAT District Council No. 21,
- if you are a Fund Employee, the end of the month following the date you stop working for the Fund, or
- the date the Plan is terminated.

**For Retirees.** Your coverage ends if:

- you stop paying the required premiums for continued coverage
- you do not properly waive coverage for yourself or your Dependents, or
- the Plan is terminated or no longer covers Retirees.

**For dependents.** Coverage for your dependents ends if:

- you die*,
- your coverage ends,
- they no longer meet the definition of "Eligible Dependent,"
- they become covered under the Plan as Active Participants,
- in the case of a Retirees, the required premium for Dependents is not paid,
- the Plan cancels dependent coverage, or
- the Plan terminates.

*If you are an Active Participant and you die while you are eligible for benefits, coverage for your dependents will continue, free of charge, for the remainder of the Benefit period in which your death occurs, plus two additional Benefit periods.

If you are a Retiree and you die while you are eligible for benefits, your dependents' coverage will continue until the end of the month in which your death occurs. After that month your dependents will be eligible for extended coverage at the applicable self-pay rate.

When your coverage under the Plan would otherwise end, you may be able to continue coverage by electing COBRA Continuation Coverage (more on this later). The Plan also has rules for limited extensions of coverage during certain absences, and they are described below.

### Continuation of Coverage During Certain Absences

**Family and Medical Leave.** If your employer has 50 or more employees, you may be eligible for leave under the Family and Medical Leave Act (FMLA). Under FMLA you may take up to 12 weeks of unpaid leave for specified family or medical purposes, such as your own serious medical condition, the birth or adoption of a child, or to provide care for a spouse, child or parent who is ill.

If you take an FMLA leave, your employer is obligated to continue to contribute to the Fund on your behalf and your coverage through the Fund will continue.

During your leave, you may continue all of your medical coverage and other benefits offered through the Fund. You are generally eligible for an FMLA leave if you:

- Worked for an employer for at least 12 months
- Worked at least 1,250 hours in Covered Employment over the previous 12 months
- Worked at a location where at least 50 employees are employed by the employer within 75 miles.

If you do not return to employment following an FMLA leave during which coverage was provided, you may be required to provide reimbursement for the cost of coverage received during the leave.

Call your employer if you have questions regarding your eligibility for an FMLA leave. Call the Fund Office regarding coverage during such a leave.

If you do not return to work after the end of your FMLA leave, you may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA, described in a later section.

**Military Leave.** If you are on active military duty for less than 31 days, you will continue to receive health care coverage from the Fund in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you are on active duty for 31 days or more, your Fund coverage ends, but USERRA permits you to continue health care coverage for you and your dependents at your own expense for 24 months This continuation right operates in the same way as COBRA coverage, which is described in the next section. In addition, your dependent(s) may be eligible for health care coverage under the federal program known as TRICARE (which includes the old "CHAMPUS" program). This Plan coordinates its coverage with TRICARE.

If you receive an honorable discharge and return to work with a contributing employer, your full eligibility will be reinstated on the day you return to work as long as you return within one of the following time frames:

- 90 days of the date of discharge, if the period of service is more than 180 days;
- 14 days from the date of discharge, if the period of service was 31 days or more but less than 181 days; or
- one day after discharge (allowing 8 hours for travel) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits may be extended.

Under USERRA an active employee is required to notify the employer (in writing or orally) that he or she is leaving for military service unless circumstances or military necessity make notification impossible or unreasonable. Your employer is required to notify the Plan within 30 days after you are reemployed following military service; however, it is a good idea for you to notify the Fund Office, too.

**Note that, for leaves of absence covered by the Family and Medical Leave Act ("FMLA") or for qualified military service, your employer must properly grant the leave and make the required notification and any required payment to the Fund. You should contact your employer to confirm that you are eligible for a leave.**

**Contact your employer if you have questions regarding your eligibility for a leave. Contact the Fund Office if you have any questions regarding Fund coverage during such a leave.**

**Continuation of coverage during disability.** If you become "disabled" while you are covered by the Plan, you may be able to continue your coverage by using the Hours Bank or Disability Credit Hours. During a period of disability, the Fund will grant you 27 "Disability Credit Hours" per week, for up to 104 weeks.

**You are considered "disabled" if you are unable to perform the duties of your occupation because of a medically determined physical or mental impairment, as certified by a physician, and you are unable to receive substantial compensation from any employment, including unemployment compensation.**

**Continuation of Health Care Coverage Under COBRA**

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), requires that this plan offer you and your eligible dependents the opportunity for a temporary extension of health care coverage at group rates in certain instances when coverage under the plan would otherwise end (called "qualifying events"). Continued coverage under COBRA applies to the medical, hospital, prescription drug, dental and vision benefits described in this booklet.

The benefits under COBRA are the same as those covering people who are not on continuation coverage. You should keep in mind that each individual entitled to coverage as the result of a qualifying event has a right to make his or her own election of coverage. For example, your spouse or other Eligible Dependent may elect COBRA coverage even if you do not. In addition, a parent or legal guardian may elect continuation coverage for a minor child.

**If you have questions about COBRA you should contact:**

**IUPAT District Council No. 21 Welfare Fund**
**2980 Southampton-Byberry Road, Philadelphia, PA 19154**
**800-252-7252 or 215-934-5130**

**Qualifying COBRA Events.** The chart below shows when you and your eligible dependents may qualify for continued coverage under COBRA, when coverage may start and when it ends.

| If You Lose Coverage Because of This Reason (a "qualifying event") | These People Would Be Eligible | For COBRA Coverage Up To (measured from the date coverage is lost) |
|---|---|---|
| **Your employment terminates*** | You and your covered spouse and children | 18 months ** |
| **Your working hours are reduced** | You and your covered spouse and children | 18 months ** |
| **You die** | Your covered spouse and children | 36 months |
| **You divorce** | Your covered spouse and children | 36 months |
| **Your dependent child no longer qualifies as an eligible dependent** | Your covered children | 36 months |
| **You become enrolled in Medicare** | Your covered spouse and children | 36 months |

*For any reason other than gross misconduct (and including military leave (up to 24 months of COBRA-type coverage available) and approved leaves granted according to the Family and Medical Leave Act).

**Continued coverage for up to 29 months from the date of the initial event may be available to those who, during the first 60 days of continuation coverage, are totally disabled within the meaning of Title II or Title XVI of the Social Security Act. This additional 11 months is available to employees and enrolled dependents if notice of disability is provided within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of coverage will increase to 150% of the full cost of coverage.

**Proof of good health is NOT required for COBRA coverage.**

**Newborn and adopted children.** If you have a newborn child, adopt a child, or have a child placed with you for adoption while continuation coverage under COBRA is in effect, you may add the child to your coverage. To add coverage for the child, notify the Fund Office within 31 days of the child's birth, adoption or placement for adoption. Legal proof of your relationship to the child must also be provided.

**Multiple Qualifying Events.** If your Eligible Dependents experience more than one qualifying event while COBRA coverage is in force, they may be eligible for an additional period of continued coverage not to exceed a total of 36 months from the date of the first qualifying event.

> **For example,** if your employment ends, you and your Eligible Dependents may be eligible for 18 months of continued coverage. During this 18-month period, if you die (a second qualifying event), your Eligible Dependents may be eligible for an additional period of continuation coverage. However, the two periods of coverage combined may not exceed a total of 36 months from the date of the first qualifying event (your termination).

This extended period of COBRA continuation coverage is **not** available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended

period of coverage is available to any child(ren) born to, adopted by, or placed for adoption with you during the 18-month period of continuation coverage.

Also note that if your first qualifying event is a reduction in hours, and then your employment is terminated, the termination of employment is not treated as a second qualifying event (so there is no extension beyond the initial 18-month period of coverage).

**Notice of COBRA eligibility**. Both you and your employer have responsibilities when qualifying events occur that make you and/or your Eligible Dependents eligible for continuation coverage.

Your employer is responsible for notifying the Fund Office of your death, termination of employment, or your reduction in hours of employment. (However, you or your family should also notify the Fund Office if such an event occurs, in order to avoid confusion as to your status.)

You or your eligible dependents are responsible for informing the Fund Office of a divorce, legal separation or a child's losing of dependent status under the Plan within 60 days of the event (and do not forget to provide address for both you and the dependent(s)). If you do not notify the Fund by the end of that period, your dependents will not be entitled to continuation coverage, and the Fund may seek reimbursement for any benefits provided during any period of ineligibility**.** You should also notify the Fund Office if you want to add a newborn, adopted or newly placed dependent child to your coverage (you may not add a new spouse to your coverage).

The Fund must notify you and/or your Eligible Dependents of your right to COBRA coverage within 14 days after it receives notice or becomes aware that a qualifying event has occurred. **You will have 60 days from the date of the coverage termination or the date of the COBRA notice, whichever is latter, to respond if you want to continue coverage.**

Where you or your dependents have provided notice to the Fund of a divorce or legal separation, a beneficiary ceasing to be covered under the plan as a dependent, or a second qualifying event, but you are not in fact entitled to COBRA, the Fund will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within the same timeframe that the Fund is required to provide an election notice.

**Procedures for providing notice to the Fund**. As described in the preceding section, as a covered employee or qualified beneficiary, you are responsible for providing the Fund with timely notice of certain qualifying events. You must provide notice of the following qualifying events:

- Divorce or legal separation from your spouse.
- A child no longer satisfies the eligibility requirements for coverage under the Plan.
- A second qualifying event occurs after a qualified beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second qualifying event could include an employee's death, divorce or legal separation, or a child losing dependent status.

In addition to these qualifying events, there are two other situations where you (or an Eligible Dependent) is responsible for providing the Fund with notice within the timeframe noted in this section:

- When a qualified beneficiary entitled to receive COBRA coverage for a maximum of 18 months has been determined by the Social Security Administration to be disabled. If this determination is made at any time during the first 60 months of COBRA coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA coverage.
- When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

You must make sure that the Fund is notified of any of the five occurrences listed above. Failure to notify the Fund in the form and within the timeframes described below may prevent you and/or your dependents from obtaining or extending COBRA coverage.

**How your notice should be provided.** Your notice must be in writing and must be sent to:

IUPAT District Council No. 21 Welfare Fund
2980 Southampton-Byberry Road
Philadelphia, PA 19154

Please include the following in your notice:

- your name,
- which of the five events described above you are reporting and the date of the occurrence, and
- your address.

**When your notice should be sent**. *If you are providing notice due to a divorce or legal separation, a dependent losing eligibility for coverage or a second qualifying event*, you must send the notice no later than **60 days after the later of** (1) the date of the relevant qualifying event; or (2) the date upon which coverage would be lost under the plan as a result of the qualifying event.

*If you are providing notice of a Social Security Administration determination of disability*, notice must be sent no later than 60 days after the date of the disability determination by the Social Security Administration.

*If you are providing notice of a Social Security Administration determination that you are **no longer** disabled*, notice must be sent no later than **30 days after** the date of the determination by the Social Security Administration that you are no longer disabled.

**Who can provide notice?** Notice may be provided by the covered employee, by the qualified beneficiary with respect to the qualifying event, or by any representative acting on behalf of the covered employee or qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if an employee, his spouse and his child are all covered by the plan, and the child

ceases to be a dependent under the plan, a single notice sent by the spouse would satisfy this requirement.

Note that each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. A parent or legal guardian may elect continuation coverage for a minor child.

**Keep the Fund Informed of Address Changes**

**In order 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.**

**Paying for COBRA coverage**. You have to pay the full cost of continued coverage as calculated under COBRA. If you are eligible for 29 months of continued coverage due to disability, the law permits the Fund to charge 150% of the full cost of the plan during the 19th to 29th months of coverage. It is easiest to make your first payment when you file your COBRA election form, that is, within 60 days from the date your Plan coverage would otherwise end. In no event may your first payment be made later than 45 days after you mail your signed election form to the Fund Office. All subsequent payments will be due on the last day of each month for the following month's coverage. You will be notified by the Fund Office if the amount of your monthly payment changes. In addition, if the benefits change for active employees, your coverage will change as well.

**Do not forget that the Fund Office does not send bills for COBRA coverage and that it is your responsibility to make COBRA payments on time. If you do not make your payments on time, your coverage will end.**

**When COBRA coverage ends**. Your continued coverage under COBRA will end if:

- Coverage has continued for the maximum 18, 29 or 36-month period.
- The group health plan of which you were a member terminates. If the coverage is replaced, you may be continued under the new coverage.
- You or your dependent(s) fail to make the necessary payments on time.
- You or an Eligible Dependent becomes covered under another group health plan that does not exclude coverage for pre-existing conditions or the pre-existing conditions exclusion does not apply.
- You or an Eligible Dependent becomes enrolled in Medicare.
- You or your dependent(s) are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

If continuation coverage is terminated before the end of the maximum coverage period, the Fund will send you a written notice as soon as practicable following the determination that continuation coverage will be terminated early.

**Consequences of failing to elect COBRA**. In considering whether to elect continuation coverage, you should take into account the effect your decision will have on your future rights under federal law.

*First*, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you avoid such a gap.

*Second*, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you.

*Finally*, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed above. You will also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.

**Special note.** If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act of 1974, you may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit. If you and/or your dependents did not elect COBRA during your election period, but are later certified by the DOL for Trade Act benefits or receive pensions managed by the Pension Benefit Guaranty Corporation (PBGC), you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA later than six months after your coverage ended under the Plan.

Also under the Trade Act, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/.

**Your Rights Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

Under the federal law called the Health Insurance Portability and Accountability Act of 1996 (commonly called "HIPAA") the Fund is required to provide the following rights.

**Special enrollment rights**. HIPAA requires that plans like ours guarantee that participants and dependents not otherwise enrolled in a plan have special enrollment rights if certain events occur, known as "qualifying circumstances" under HIPAA. Qualifying circumstances include:

- A change in family status, such as marriage, divorce, birth, adoption, placement for adoption, or death. Under these circumstances coverage takes effect on the first day of the month following the month in which your other coverage terminated, provided coverage is requested within 60 days of the applicable event.

- You previously stated in writing that you and or your dependents were waiving Fund coverage because of coverage under another medical plan, and that other coverage is lost for any of the following reasons:
    - termination of employment;
    - reduction in hours worked;
    - your spouse dies;
    - you and your spouse divorce or legally separate;
    - the other coverage was COBRA continuation coverage, and you or your dependent reaches the maximum length of time for COBRA continuation coverage; or
    - the other plan terminates because the employer [or other sponsor] did not pay the premium when due.

More information about these rights is available from the Fund Office.

**Certificate of Creditable Coverage.** When your Fund coverage ends, you and/or your dependents will be provided with, a "Certificate of Creditable Coverage." Certificates of Creditable Coverage indicate the period of time you and/or your dependents were covered under the Fund (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you are covered under a health insurance policy, within 63 days after your coverage under this Fund ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to you and/or your dependents under the new group health plan or health insurance policy.

The Certificate of Creditable Coverage will be provided to you:

- on your request, within 24 months after your Fund coverage ends
- when you are entitled to elect COBRA
- when your coverage terminates, even if you are not entitled to COBRA
- when your COBRA coverage ends.

You should retain these Certificates of Creditable Coverage as proof of prior coverage for your new health plan. For further information, call the Fund Office.

**Other HIPAA rules.** This Plan is a covered entity under HIPAA's privacy regulations. For the Fund's "Notice of Privacy Practices," please see the Section of this document titled: "HIPAA Protected Health Information."

### Conversion Privilege

When your Fund coverage ends, including COBRA coverage, you and/or your Eligible Dependents may be entitled to convert your medical coverage to individual contracts with Capital Blue Cross. You generally have a limited number of days to exercise this right. For more information, review your medical benefits summary or call Capital Blue Cross. For information on converting your life insurance coverage, see the section on those benefits.

# HOSPITAL AND MEDICAL BENEFITS

Effective July 1, 2003 the Fund entered into a contract of insurance with Capital Blue Cross in order to provide benefits to all Active Participants, Retirees and eligible Dependents.

Capital Blue Cross benefits booklets and information are available through the Fund office, and include a comprehensive description of benefits, exclusions, limitations, and claims and appeals procedures.

The Group Number for this plan is 505842.

**Capital Blue Cross PPO Plan**

**If you do not have a summary of the Capital Blue Cross PPO Plan benefits, call the Fund Office.**

**If you have a question that the summary does not answer, call Capital Blue Cross at 800.348.8172.**

**You can also get more information online at www.capbluecross.com.**

Capital BlueCross

www.capbluecross.com

***Benefit Highlights***
***PPO Plan***
**IUPAT DC21 Welfare Fund**
**80/60 Plan**

| SUMMARY OF COST-SHARING | Amounts *Members* Are Responsible For: | |
|---|---|---|
| | *Participating Providers* | *Non-Participating Providers* |
| **Deductible** (per benefit period)<br>***Deductible applies to all services unless a Copayment is applied or otherwise noted*** | $500 per member<br>$1,500 per family | $1,000 per member<br>$3,000 per family |
| **Copayments** | | |
| • Office Visits (Family Practitioner, General Practitioner, Internist, Pediatrician) | $ 35 copayment per visit | Coinsurance applies |
| • Specialist Office Visit | $ 35 copayment per visit | Coinsurance applies |
| • Emergency Room | $ 75 copayment per visit, waived if admitted | |
| • Urgent Care | $ 75 copayment per visit | Coinsurance applies |
| • Inpatient (Per Admission) | Not Applicable | Coinsurance applies |
| • Outpatient Surgery Copayment (facility) | Not Applicable | Coinsurance applies |
| **Coinsurance** | 20% coinsurance | 40% coinsurance |
| **Out-of-Pocket Maximum** | $2,000 per member<br>$6,000 per family | $4,000 per member<br>$12,000 per family |
| **Coverage Lifetime Maximum** | None | |

| SUMMARY OF BENEFITS | Limits and Maximums | Amounts *Members* Are Responsible For: | |
|---|---|---|---|
| | | *Participating Providers* | *Non-Participating Providers* |
| **PREVENTIVE CARE:** *Administered in accordance with Preventive Health Guidelines and PA state mandates* | | | |
| **Preventive Care Services** | | | |
| • Pediatric Preventive Care | | Covered in full, waive deductible | 40% coinsurance after deductible |
| • Adult Preventive Care | | Covered in full, waive deductible | 40% coinsurance after deductible |
| **Immunizations** | | Covered in full, waive deductible | 40% coinsurance, waive deductible |
| **Mammograms** | | | |
| • Screening Mammogram | One per benefit period | Covered in full, waive deductible | 40% coinsurance, waive deductible |
| • Diagnostic Mammogram | | Covered in full after deductible | 40% coinsurance after deductible |
| **Gynecological Services** | | | |
| • Screening Gynecological Exam | One per benefit period | Covered in full, waive deductible | 40% coinsurance, waive deductible |
| • Screening Pap Smear | One per benefit period | Covered in full, waive deductible | 40% coinsurance, waive deductible |
| **BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET** | | | |
| **Acute Care Hospital Room & Board** | | 20% coinsurance after deductible | 50% coinsurance after deductible |
| **Acute Inpatient Rehabilitation** | 60 days/benefit period | 20% coinsurance after deductible | 50% coinsurance after deductible |
| **Skilled Nursing Facility** | 100 days/benefit period | 20% coinsurance after deductible | 50% coinsurance after deductible |
| **Surgery** | | | |
| • Surgical Procedure | | 20% coinsurance after deductible | 40% coinsurance after deductible |
| • Anesthesia | | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Maternity Services and Newborn Care** | | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Diagnostic Services** | | | |
| • Radiology | | 20% coinsurance after deductible | 40% coinsurance after deductible |
| • Laboratory | | 20% coinsurance after deductible | 40% coinsurance after deductible |
| • Medical tests | | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Outpatient Therapy Services** | | | |
| • Physical Medicine | 30 visits/benefit period | Copayment applies | 40% coinsurance after deductible |
| • Occupational Therapy | 30 visits/benefit period | Copayment applies | 40% coinsurance after deductible |
| • Speech Therapy | 30 visits/benefit period | Copayment applies | 40% coinsurance after deductible |
| • Respiratory Therapy | 30 visits/benefit period | Copayment applies | 40% coinsurance after deductible |
| • Manipulation Therapy | 20 visits/benefit period | Copayment applies | 40% coinsurance after deductible |
| **Emergency Services** | | Covered in full, waive deductible<br>Emergency room copayment applies, waived if admitted inpatient | |
| **Medical Transport** | | | |
| • Emergency Ambulance | | 20% coinsurance, waive deductible | |
| • Non-Emergency Ambulance | | 20% coinsurance after deductible | 40% coinsurance after deductible |

**Benefits are underwritten by Capital Advantage Insurance Company®, a subsidiary of Capital BlueCross.** Independent licensee of the Blue Cross and Blue Shield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

PPOE1
07/01/2011

Large Group – PPO-HCR
(10/1/2010)

| SUMMARY OF BENEFITS (CONTINUED) | Limits and Maximums | Amounts Members Are Responsible For: | |
|---|---|---|---|
| | | *Participating Providers* | *Non-Participating Providers* |
| **Mental Health Care Services**<br>• Inpatient Services | | 20% coinsurance after deductible | 40% professional and 50% facility coinsurance after deductible |
| • Outpatient Services | | Copayment applies | 40% professional and 50% facility coinsurance after deductible |
| **Substance Abuse Services**<br>• Rehabilitation – Inpatient | | 20% coinsurance after deductible | 40% professional and 50% facility coinsurance after deductible |
| • Rehabilitation – Outpatient | | Copayment applies | 40% professional and 50% facility coinsurance after deductible |
| **Home Health Care Services** | 90 visits/benefit period | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Hospice Care** | $50,000 lifetime max | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Durable Medical Equipment (DME)** | | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Prosthetic Appliances and Orthotic Devices** | | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Diabetic Supplies and Education** | | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Infertility Services** | | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Assisted Fertilization** | | Not Covered | Not Covered |
| **Nutritional Counseling**<br>• Children Diagnosed with Obesity and<br>• Adults with BMI of 30 or Higher | | Not Covered | Not Covered |

| OTHER STANDARD PLAN FEATURES | |
|---|---|
| **Preauthorization** | Preauthorization is a clinical program in which our nurses work with physicians to approve and monitor certain health care services prior to the delivery of services. The purpose of Preauthorization is to ensure all members receive medically appropriate treatment to meet their individual needs. |
| **Disease Management** | Disease Management Programs are a collaborative process that assess the health needs of a member with a chronic condition and provides education, counseling and on-demand information designed to increase a member's self-management of his/her diabetes, asthma, heart disease, and/or depression. |
| **Nurse Line** | Nurse Line is staffed 24 hours a day, 7 days a week by experienced Registered Nurses to provide information and support for any health-related concern. Call 800-452-BLUE. |
| **Better Health Works℠ Personal Profile** | Answer questions about yourself and the way you live and, based on the answers you provide, you will receive customized recommendations for your health situation. Support is available to follow through on these recommendations and to make positive health changes. |
| **mycapbluecross.com** | Members register for on-line access to their personal account to check claim status, compare hospital quality and treatment costs, print temporary proof of coverage, read the SimplyWell℠ member newsletter, view explanation of benefits, and much more. |

**STANDARD BENEFIT EXCLUSIONS.** The following list highlights *some* standard benefit exclusions. It is **NOT** intended to be a complete list or a complete description of all categories of benefit exclusions.

Cosmetic procedures – Acupuncture – Routine foot care; or support devices of the feet – Eyeglasses, contact lenses, or vision examinations for prescribing or fitting eyeglasses or contact lenses – Corneal surgery and other procedures to correct refractive errors – Prescription and over-the-counter drugs dispensed by a pharmacy or home health care agency provider – Hearing aids or examinations for the prescription or fitting of hearing aids – All dental services rendered after stabilization of a member in an emergency following an accidental injury – Treatment of obesity, except for surgical treatment of morbid obesity – Any treatment leading or relating to or in connection with assisted fertilization, including donor services – Certain non-neonatal circumcisions - Private duty nursing services

**THIS IS NOT A CONTRACT.** This information highlights *some* of the benefits available through this program and is **NOT** intended to be a complete list or complete description of available services. Refer to your Certificate of Coverage for benefit details.

Inpatient admissions as well as certain other services and equipment may require preauthorization.

Participating providers agree to accept our allowance as payment in full—often less than their normal charge.

If you visit a non-participating provider, you are responsible for paying the deductible, coinsurance and the difference between the non-participating provider's charges and the allowable amount. Non-Participating Providers may balance bill the member. Some non-participating facility providers are not covered.

For more information or to locate a participating provider, visit www.capbluecross.com.

Refer to your Certificate of Coverage or contact your employer for the applicable benefit period.

Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for group size > 51.

PPOE1
07/01/2011

Large Group – PPO-HCR
(10/1/2010)

## Legal Guarantees

You should be aware of certain rights provided by law.

## Important Notifications

**Minimum maternity stay.** Under the federal law called the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) a plan may not restrict a mother's or a newborn child's benefits for a hospital stay to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, this law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours.

**Reconstructive surgery**. Under the Women's Health and Cancer Rights Act of 1998, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. Benefits for reconstructive breast surgery following a mastectomy will be provided on the same basis as other surgical procedures covered by the Plan, and include:

- reconstruction of the breast on which a mastectomy is performed,
- reconstructive surgery on the other breast to produce a symmetrical appearance,
- breast prostheses and surgical bras following a mastectomy, and
- physical complications of any stage of mastectomy, including lymphedemas.

## Filing a Claim

For information on how to file a claim for your medical benefits, see the section called "Benefit Claim Determinations and Appeals."

# PRESCRIPTION DRUG BENEFITS

The prescription drug benefit, which is administered by Express Scripts ("ESI"), provides coverage for many drugs that require a doctor's prescription. The benefits described in this section are available to Active Participants, Eligible Dependents, and Retirees.

## How It Works

You can get prescription drugs in two different ways – from a participating pharmacy, a non-participating pharmacy, or, in the case of "maintenance medications," by mail, through the Express Scripts mail order pharmacy.

## Retail Pharmacy Benefits

When you purchase covered drugs from a Participating Pharmacy, you should present your prescription order and your identification card to the pharmacist. The pharmacist will use a computerized system to confirm your eligibility for benefits and determine the cost of your prescription, including the share of the cost you will be asked to pay.

If you utilize a pharmacy that does not participate with Express Scripts, Inc., it will be necessary for you to pay the pharmacy's regular charge for the prescription. Then you must complete and sign a claim form, including the specified drug and patient information. Send it along with a receipt to Express Scripts at: P.O. Box 390873, Bloomington, MN 55439-0873 Attention: Claims Department. Your reimbursement check should arrive in ten to fourteen (10-14) business days from the day your claim form is received. Reimbursements are limited to the Express Scripts allowance for the prescription purchased, which may be less than the retail price you paid at a Non-Participating Pharmacy. Claim forms are available at the Fund Office.

**To find a network pharmacy, you can call Express Scripts at 800-467-2006, or go to their website at www.express-scripts.com and click on "Pharmacy Locator."**

## Mail Order Prescriptions

This program provides you with the convenience of receiving prescription maintenance medication right at your home through the Express Scripts mail order pharmacy. The purpose of the program is to offer maintenance drugs used for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc. If you are taking medications frequently and for a long period of time, a three month supply can be delivered to your home.

When your doctor prescribes chronic or maintenance drug therapies, simply ask him to prescribe a ninety (90) day supply, plus three (3) refills. Maintenance drugs are recognized for the treatment of chronic or long term conditions such as, cardiac disease, hypertension, diabetes, lung disease and arthritis.

To order from Express Scripts pharmacy, you'll need an order form, which is available from Express Scripts (1-800-467-2006) or the Fund Office. Enclose your prescription (no photocopies) in the pre-addressed envelope, follow the directions on the envelope and make certain that you include appropriate payment

## What is Covered?

Benefits will be provided for covered drugs for out-of-hospital use, when prescribed by a legally licensed physician and dispensed by a legally licensed pharmacy on and after the coverage effective date. This benefit includes prescription orders which the pharmacy receives by phone from your doctor. Benefits are available for up to a thirty (30) day supply at the retail pharmacy and a ninety (90) day supply through the mail order pharmacy. However, if you are taking medication on a long-term, continuous basis for chronic ailments such as high blood pressure, heart condition, diabetes, asthma, arthritis, oral contraceptives, etc., that item will be available at the retail pharmacy for a maximum 30-day supply and two (2) refills. Thereafter, you must receive your maintenance medications through the Express Scripts mail order pharmacy.

## Copayment

The following copayment(s) will be made by you for each separate prescription order and refill:

| Prescription | Retail Copayment | Mail Copayment |
|---|---|---|
| ***Generic Prescription*** | **$20 Copayment** | **$40 Copayment** |
| ***Brand Name* Prescription*** | **$30 Copayment** | **$60 Copayment** |

*If you choose a Preferred Brand or a Non-Preferred Brand when there is a Generic available, you will be responsible for the above captioned copayment plus the difference between the least costly generic and brand name medication. While you are not required to utilize generic drugs if you or your doctor prefers the brand name drug, you will have higher out of pocket expense.

## Generic Drugs

Generic alternatives have the same chemical makeup and same effect in the body as an original brand name drug, except generics usually have a different name, color and/or shape. Generics have been rigorously tested by the U.S. Food & Drug Administration (FDA) and approved as safe and effective.

Unlike manufacturers of brand name drugs, the companies that make generic drugs do not spend a great deal of money on research and advertising. So their generic drugs cost less than the original brand name – and the savings are passed on to you in the form of a lower copayment.

In addition, the Fund has the following Prior Authorization, Step-Therapy, Drug Quantity Management Programs. Additional information can be provided by Express Scripts and the Fund Office.

## Prior Authorization

Prior Authorization promotes clinically appropriate and cost-effective medications. It ensures that prescribed medications are being used for their appropriate indications. On-line messaging alerts the pharmacist of the required intervention.

A list of drugs included in the Prior Authorization Program is available by contacting Express-Scripts or the Fund Office.

Prior Authorization may be obtained by contacting the Fund Office or by having your Physician contact Express Scripts directly.

## Step Therapy

Step Therapy is a program especially for people who take prescription drugs regularly to treat an ongoing medical condition, such as arthritis, asthma or high blood pressure. The program is a new approach to getting you the prescription drugs you need, with safety, cost and – most importantly – your health in mind.

The program makes prescription drugs more affordable for most members and helps the District control the rising cost of drugs. It allows you and your family to receive the affordable treatment you need and also helps the Fund continue with prescription-drug coverage.

In Step Therapy, the covered drugs you take are organized in a series of "steps," with your doctor approving and writing your prescriptions.

- The program usually starts with ***generic drugs in the "first step."*** Rigorously tested and approved by the U.S. Food & Drug Administration (FDA), the generics covered by the plans have been proven to be effective in treating many medical conditions. This first step allows you to begin or continue treatment with safe, effective prescription drugs that are also affordable: Your copayment is usually the lowest with a first-step drug.
- More expensive ***brand name drugs are usually covered in the "second step,"*** even though the generics covered by our plans have been proven to be effective in treating many medical conditions.

Your doctor is consulted, approving and writing your prescriptions based on the list of Step Therapy drugs covered by the plan. For instance, your doctor must write your new prescription when you change from a second-step drug to a first-step one.

Step Therapy is developed under the guidance and direction of independent, licensed doctors, pharmacists and other medical experts. Together with Express Scripts – the company chosen to manage our pharmacy benefit plan – they review the most current research on thousands of drugs tested and approved by the FDA for safety and effectiveness. Then they recommend appropriate prescription drugs for a Step Therapy program, and our organization's prescription benefit plan chooses the drugs that will be covered.

A list of drugs included in the Step Therapy Program is available by contacting Express-Scripts or the Fund Office.

### What Happens at the Pharmacy with Step Therapy

The first time you submit a prescription that isn't for a first-step drug, your pharmacist will tell you there's a note on the computer system indicating that your plan uses Step Therapy. This simply means that if you'd rather not pay full price for your prescription drug, your doctor needs to give you a prescription for a first-step drug.

To receive a first-step drug:

- ***Ask your pharmacist to call your doctor*** and request a new prescription,

***OR***

- ***Contact your doctor*** to get a new prescription.

Only your doctor can change your current prescription to a first-step drug covered by your program.

At the pharmacy, you may be informed that your drug isn't covered if you have just started taking a prescription drug regularly or if you are a new member of our plan. If this occurs and you need your medication quickly, you can:

- ***Talk with your pharmacist about filling a small supply*** of your prescription right away. You may have to pay full price for this drug. Then, ask your doctor to write you a new prescription for a first-step drug, so you are sure your medication will be covered by our plan. Remember: Only your doctor can approve and change your prescription to a first-step drug.

### To Receive a Second-Step Drug

With Step Therapy, more expensive brand name drugs are usually covered in a later step in the program if:

1) you have already tried the generic drugs covered in our Step Therapy program,
2) you can't take them (for instance, because of an allergy), or
3) your doctor decides you need a brand name drug, for medical reasons.

If one of these applies to you, your doctor can ask for a "prior authorization" for you to take a second-step prescription drug. Once the prior authorization is approved, you pay the appropriate copayment for this drug. If the prior authorization is not approved, you may need to pay the full price for the drug.

### Drug Quantity Management:

Drug Quantity Management (DQM) is a program in your pharmacy benefit that's designed to make the use of prescription drugs safer and more affordable. It provides you with medicines you need for your good health and the health of your family, while making sure you receive them in the amount - or quantity - considered safe.

Certain medicines are included in this program. For these medicines, you can receive an amount to last you a certain number of days: For instance, the program could provide a maximum of 30 pills for a medicine you take once a day. This gives you the right amount to take the daily dose considered safe and effective, according to guidelines from the U.S Food & Drug Administration (FDA).

A list of drugs included in the Drug Quantity Management Program is available by contacting Express-Scripts or the Fund Office.

**Exclusions**

The following items are not covered by the Prescription Plan:

- Drugs dispensed without a prescription drug order except insulin, syringes, needles and diabetic pump supplies;
- Prescription drugs which by law may be dispensed without a prescription drug order even though a prescription drug order may be written for the drug;
- Prescription drugs obtained through mail order prescription drug services of a non member mail order pharmacy;
- Devices of any type even though such devices may require a prescription drug order including, but not limited to contraceptive devices, ostomy supplies, therapeutic devices, artificial appliances. This exclusion does not apply to devices used for the treatment or maintenance of diabetic conditions and syringes used for the injection of insulin;
- Prescription drugs dispensed to you while you are a patient in a facility including, but not limited to, a hospital, skilled nursing facility, institution, health care practitioner's office or free-standing facility;
- Prescription drugs which are not medically appropriate;
- Prescription drugs used for cosmetic purposes as determined as not part of the medically appropriate treatment of an illness, injury or congenital birth defect (for example, Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old);
- Prescription drugs which are experimental or investigative;
- Prescription drugs which are not prescribed by an appropriately licensed health care practitioner;
- Prescription drugs for any loss sustained or expenses incurred as a member of the armed forces of any nation while on active duty; or losses sustained or expenses incurred as a result of enemy action or act of war, whether declared or undeclared; drugs for which benefits are provided by the Veteran's Administration or by the Department of Defense for the covered person of the armed forces of any nation while on active duty;
- Prescription drugs for any occupational illness or bodily injury arising out of, or in the course of, employment for which you have a valid and collectible benefit under any Worker's Compensation Law, United States Longshoreman's Act or Harbor Worker's Compensation Act, Occupational Disease Act or Law, whether or not you claim the benefits or compensation;
- Prescription drugs for which you have no obligation to pay;
- Prescription drugs furnished without charge to the covered person;
- Prescription drugs which have been paid under the Health Plan.

- Dietary Supplements, amino acid supplements and health foods and prescription vitamins except for pre-natal vitamins;
- Smoking deterrent agents;
- Prescription drugs used for the treatment of infertility;
- The administration or injection of drugs;
- Prescription drugs which have been prescribed for sexual dysfunction; regardless of the medical necessity;
- Blood and blood products;
- Intravenous drugs and intravenous solutions administered by home infusion companies;
- Prescription drugs for a use not approved by the U.S. Food and Drug Administration or a dosage that is not recommended by the U.S. Food and Drug Administration.

**If you have any questions about your prescription drug benefits, call Express Scripts at 800-467-2006. You can access their website at www.express-scripts.com.**

## Filing a Claim

For more information on filing a claim for prescription drug benefits, see the section called "Benefit Claim Determinations and Appeals."

# DENTAL BENEFITS

Fidelio Dental Insurance Company "Fidelio" (2826 Mount Carmel Avenue, Glenside, PA 19038 Tel: 215-885-2443 or 1-800-262-4949, www.Fideliodental.com) administers the program on behalf of the Fund on a self-insured basis.

The benefits described in this section are available to Active Participants, Eligible Dependents, and Retirees. The Fund's dental coverage provides benefits based on a contract year (July 1 – June 30). Dental benefits are provided by Fidelio ("Fidelio").

**IMPORTANT: The actual insurance policy issued by Fidelio is what controls the dental benefits offered under this Plan. If there is a conflict between the contents of this SPD and the insurance policy issued by Fidelio, then the insurance policy shall control. You can contact the Fund Office if you would like to review a copy of the Fidelio insurance policy.**

**Covered Benefits**

The dental benefit covers the following types of services:

- **Diagnostic Care** – Procedures to assist dentists to evaluate existing conditions and dental care required – this includes visits, exams, diagnosis and x-rays (exams and bitewing x-rays once in any six-month period).
- **Preventive Care** – Prophylaxis (cleaning once in any six-month period), fluoride treatments (limited to age 19), space maintainers, sealants (to age 14, once in any 36 months on unfilled permanent first and second molars).
- **Basic Restorative Services** – Amalgam and composite fillings.
- **Major Restorative Services** – Crowns, inlays and onlays are covered when other services are not adequate.
- **Oral Surgery** – Extraction and oral surgery procedures including pre- and post-operative care.
- **Endodontics** – Procedures for pulpal therapy and root canal filling.
- **Periodontics** – Surgical and non-surgical procedures for treatment of gums and supporting structures of teeth.
- **Prosthodontics –** Procedures for construction or repair of fixed bridges, partial or complete dentures.
- **Orthodontics** - Procedures for straightening teeth.
- **Denture Repair (Plan A only) –** Repair of existing dentures.
- **Bleaching & Teeth Whitening –** The Plan allows up to $300 per year with a co-pay of 50% by the patient for in-home treatment. In addition, the Plan will allow $500 for one treatment per year with a co-pay of 50% by the patient for an in-office treatment.
- **Night Guards (Bite Appliances) –** The Plan will allow coverage once every three years with a co-pay of 50% by the patient.

## How It Works

How the dental benefit works depends on the following:

- When you go to a **participating** dentist, the Plan pays a percentage of the dentist's charge, as shown on the schedule of benefits. You are responsible for the remaining amount.
- When you go to a **non-participating** dentist, the Plan pays a percentage of the Usual, Customary and Reasonable Allowance ("UCR") established by Fidelio. The UCR is the maximum amount Fidelio recognizes for a particular service. You will be responsible for the remaining percentage, in addition to any amount above the UCR.

**To obtain a list of participating providers, you can call Fidelio at 1-800-262-4949 or visit their website at www.Fideliodental.com.**

## Predetermination Review Estimates

A predetermination review gives you and your dentist advance notice of what benefits will be provided by the Plan before your treatment begins. Predetermination review is mandatory if the prescribed course of treatment is expected to cost $300 or more. You and your dentist must complete a pretreatment review form for submission to Fidelio. After Fidelio reviews the form, both you and your dentist will receive a predetermination voucher estimate.

## Schedule of Dental Benefits

The Plan covers the services listed in the following schedule up to an annual maximum of $1,500 per person. Orthodontics are offered only for Dependents up to age 19.

| "Fidelio Plan A" - DENTAL BENEFITS | | |
|---|---|---|
| **Covered Services** | **Fidelio Pays This Percentage of UCR:** | **You Pay This Percentage of UCR: (plus any amount in excess of UCR charged by a non-participating dentist)** |
| Preventive | 100% | 0% |
| Diagnostic | 100% | 0% |
| Basic Restorative | 80% | 20% |
| Major Restorative | 50% | 50% |
| Oral Surgery | 80% | 20% |
| Endodontics | 80% | 20% |
| Periodontics | 80% | 20% |
| Prosthodontics | 50% | 50% |
| Denture Repair | 80% | 20% |
| Orthodontics IN NETWORK<br><br>OR<br><br>Orthodontics OUT OF NETWORK | 100% up to $3,000 Lifetime maximum<br><br><br><br>50% up to $1,500 Lifetime maximum | Amounts over $3,000<br><br><br><br>50% up to $1,500 and amounts over $1,500 |

## What is Not Covered

The dental benefit excludes the following types of services and supplies:

- Treatment or materials which are benefits under Medicare or Medicaid unless this exclusion is prohibited by law.
- Treatment or material with respect to congenital skeletal malformation or treatment of enamel hypoplasia (lack of development), except that this exclusion shall not affect eligible newborn children as described in the definition of Dependent so long as such

dependent children continue to be eligible. When services are not excluded under this provision as to dependent children who continue to be eligible, other limitations and exclusions of this Section shall specifically apply.

- Treatment that increases the vertical dimension of an occlusion, replace tooth structure lost by attrition or erosion, or otherwise unless it is part of a treatment dentally necessary due to accident or injury and directly attributable thereto.
- Treatment or materials primarily for cosmetic purposes including but not limited to treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a treatment dentally necessary due to accident or injury and directly attributable thereto. If services are not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent or near the affected ones is excluded.
- Treatment or materials in which there is NO legal obligation to pay.
- Services provided or material furnished prior to your effective eligibility date unless this treatment was a year in duration and was completed after you became eligible except insofar as the limitations of this Section do not apply.
- Periodontal plaque control programs, including oral hygiene instruction programs.
- Preventive plaque control programs, including oral hygiene instruction programs.
- Myofunctional therapy.
- Temporomandibular joint dysfunction.
- Prescription Drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia.
- Implants and related services.
- Experimental procedures which have not been accepted by the American Dental Association.
- Services provided or material furnished after the termination date of coverage.
- Treatment or materials provided in a hospital or any other surgical treatment facility.
- Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- Replacement of existing restoration for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.

**The Dental Benefit limits the following types of services and supplies:**

**Limitation on Optional Treatment Plan**. In all cases where there are optional plans of treatment carrying different treatment costs, payment will be made for the applicable percentage of the least costly course of treatment, so long as treatment will restore the oral condition in a professionally accepted manner, with the balance of the treatment cost remaining the individuals responsibility. Such optional treatment includes, but is not limited to, specialized techniques involving gold, precision partial characterization such as jewels or lettering, shoulders on crowns or other means of unbundling procedures into individual components not customarily performed alone in generally accepted dental practices.

**Limitation on Major Restorative Benefits**. If a tooth can be restored with amalgam, synthetic porcelain or plastic, but you and your Dentist select another type of restoration the obligation of the Fund shall be to pay the applicable percentage of the fee appropriate to the least costly restorative procedure. The balance of the treatment shall be considered a dental treatment excluded from coverage of the dental care program. Replacement of crowns, jackets, inlays and onlays shall be provided no more often than in any five-year period and then only in the event that the existing crown, jacket, inlay or onlay is not satisfactory and cannot be made satisfactory. The five-year period shall be measured from the date on which the restoration was last supplied,

**Limitation on Diagnostic Aids**. Full mouth x-rays and panorex x-rays accompanied by bitewing x-rays are limited to once in any three year period. Bitewing x-rays are limited to once in any six-month period. Periodic examinations of the full mouth are limited to once in any six month period.

**Limitation on Prophylaxis, Fluoride and Sealants**. Prophylaxes and fluoride application may be performed either together or separately. Prophylaxes are limited to once in any six month period. Fluoride applications as a benefit are limited to once in any six month period up to age 19. Application of sealants as a benefit has no age limitation through the completion of the procedure or the date eligibility terminates, whichever occurs first. Treatment with sealants as a covered service is limited to applications to eight posterior teeth. Application to deciduous teeth or teeth with caries are not covered services. Sealants will be replaced only after three (3) years have elapsed following any prior provision of such material.

**Limitation on Occlusal Restorations**. Single-surface occlusal restorations of a tooth to which a sealant has been applied within twelve months, and two or three surface restorations within six months, which include occlusal surfaces on which sealants have been placed are not covered. If a single-surface occlusal restoration is performed on a tooth from twelve to thirty-six months after a sealant has been applied to that tooth, the obligation of the Fund shall be only to pay the fee appropriate to the restoration in excess of the fee paid for the application of sealant.

**Limitation on Composite Fillings**. Replacement of composite fillings on permanent posterior teeth shall be provided no more often than once in any 24-month period. The 24-month period shall be measured from the date on which the restoration was last supplied.

**Limitation on Prosthodontic Benefits**. Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to make such appliance fit will be provided. Prosthodontic appliances and abutment crowns will be replaced only after five (5) years have elapsed following any prior provision of such appliances and abutment crowns under any plan procedure.

**Limitation on Oral Surgery Benefits**. Benefits are for specific oral surgery procedures, including but not limited to reduction of fractures, removal of tumors, and removal of impacted teeth payable under a medical insurance contract or a medical or hospital service contract by which your coverage shall be determined first. The Fund's obligation for these oral surgery services shall be limited to the difference between benefits paid under such other contracts up to the Modified Usual Customary and Reasonable Fee for the procedure less the applicable deductible and patient co-insurance. When there is no medical or hospital coverage, the Fund's obligation for oral surgery Services shall be limited to the Usual Customary and Reasonable Fee for those services provided under this Section less the applicable deductible and patient co-insurance.

**Limitation on Periodontal Surgery**. Benefits for periodontal surgery in the same quadrant are limited to once in any five year period. The five year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant.

**Filing a Claim**

For information on filing a claim for dental benefits, see the section called "Benefit Claim Determinations and Appeals."

# VISION BENEFITS

National Vision Administrators, Inc. (1200 Route 46 West, Clifton, New Jersey 07013 Tel: 1-866-468-2393), administers the program on behalf of the Fund on a self-insured basis. The IUPAT Sponsor Number for NVA benefits is #07720001. The benefits described in this section are available to Active Participants, Eligible Dependents, and Retirees.

**How It Works -** You can use an NVA provider or a provider of your choosing.

**In-network providers** will include a panel of qualified ophthalmologists and optometrists. When utilizing a participating NVA provider, your examination, and lenses including single, bifocal, trifocal or lenticular lenses will be covered in full. In addition, the Plan provides a $30 wholesale cost allowance for frames. The $30 wholesale cost allowance is equivalent to approximately $90 in retail dollars. In addition, the participating NVA provider is only allowed to charge the wholesale cost plus 20% for frames with a wholesale allowance greater than the Plan allowance of $30. In addition, lens options will be available at the wholesale cost plus 20%:

In lieu of glasses, contact lenses will be covered up to $75 excluding the examination fee. Participating NVA providers will charge their usual, customary, and reasonable fee less 25%.

**The lenses, frames and lens options are discounted significantly by NVA participating providers. This provides a savings to you and you will incur less out-of-pocket expense.** If you make an appointment with an NVA participating provider, you should tell them that your coverage is administered by NVA and provided by Sponsor #07720001. NVA participating providers will submit your claim directly to NVA for processing. For a list of participating providers, call NVA at 800-672-7723 or look online at www.e-nva.com.

**Out-of-network providers –** You will be required to pay the full cost of services and supplies and the Plan will reimburse you up to the amount shown on the schedule of benefits.

| **Out-of-Network Vision Benefit** | **Out-of-Network Allowance**<br>(The Fund will reimburse you the following amounts) |
|---|---|
| Examination | Up to $30 |
| Single Vision Lenses (pair) | Up to $24 |
| Bifocal Vision Lenses (pair) | Up to $36 |
| Trifocal Vision Lenses (pair) | Up to $46 |
| Lenticular Vision Lenses (pair) | Up to $72 |

| **Out-of-Network Vision Benefit** | **Out-of-Network Allowance**<br>(The Fund will reimburse you the following amounts) |
|---|---|
| Frames | Up to $25 |
| Cosmetic Contact Lenses (including examination) | Up to $48 |
| Contact Lenses -if "medically necessary"**<br><br>(not for cosmetic purposes) | Up to $75<br><br>(including examination) |

"**Medically necessary**" means that the contact lenses are needed for one of the following:

- after cataract surgery,
- to correct visual acuity problems that cannot be corrected to 20/70 with glasses,
- to correct for extreme Anisometropia, or
- Keratoconus.

**Covered Services**

- Age 19 and under: comprehensive eye exam and lenses or contacts once every 12 months, and frames once every 24 months.
- Age 20 and older: comprehensive eye exam and glasses (lenses and frames) or contacts once every 24 months.

Examinations include, but are not limited to:

- Case history
- Examination for pathology or anomalies (internal and external)
- Occupational vision analysis
- Refraction
- Coordination test measurements
- Near point visual functions analysis
- Visual field charting (when necessary), and

- Electric tonometry (glaucoma test).

## What's Not Covered

The Plan does not cover the following:

- Medical or surgical treatment of the eye
- Drugs or medications
- Non-prescription lenses
- Two Pair of glasses in lieu of bifocals
- Subnormal visual aids
- Examinations or materials not listed as covered services
- Replacement of lost, stolen, broken or damaged lenses
- Contact lenses or frames except at normal intervals when service is otherwise available
- Services or materials provided by federal, state, local government or Workers' Compensation
- Examination, procedure training or materials not explicitly covered
- Industrial (3 mm) safety lenses and safety frames with side shields
- Sunglasses
- Parts or repair of frames.

If you obtain any of the services or supplies in this list, you will be responsible for the entire cost.

## Additional benefits

In addition to your benefits there are significant discounts available for Laser Eye Surgery. Find out more on the NVA website www.e-nva.com.

There are also discounts available for home delivery of contact lenses through Contact Fill. Find out more on the Contact Fill website www.contactfill.com

## Filing a Claim

To file a claim for vision benefits for non-participating NVA providers, you must submit a copy of the itemized receipt along with your name, ID number or a copy of your NVA ID card to:

National Vision Administrators
P.O. Box 2187
Clifton, NJ 07015

For more information on claims, see the section called "Benefit Claim Determinations and Appeals."

# WEEKLY DISABILITY BENEFIT

This benefit provides a weekly income to eligible Active Participants in the event of a disabling accident, illness, or pregnancy. To be eligible for disability benefits, the injury or illness must have occurred off the job and prevent you from working. This benefit is provided through the Fund Office.

**Eligibility Requirements**

To be eligible for weekly disability benefits, your disability cannot begin before your initial Benefit period. You are not eligible for benefits if you become ill or injured after you leave Covered Employment, even if you are still eligible for other benefits under the Plan.

**What the Benefit is**

You are entitled to receive a weekly benefit of $350.

**Definition of "Disability"**

In order to be considered disabled, you must meet the following criteria:

- a "qualified, licensed, professional" determines that you are unable to perform your job duties because of a physical or mental impairment, and
- you are unable to receive substantial compensation from any employment or unemployment compensation.

**The Trustees may require that you submit to periodic medical examinations to be eligible for disability benefits.**

**Note that generally disability benefits are subject to taxes just like wages. Social Security taxes will be automatically deducted, but federal income tax will not be withheld unless you make a written request to the Fund Office, specifying the amount you want withheld.**

**When Payments Start and End**

Benefits begin on the first full day of disability resulting from an accident, or on the 8th consecutive day of disability resulting from an illness or pregnancy. Benefits continue for as long as you are disabled, up to a maximum of 26 weeks for any one period of disability.

**If you recover from your disability** before the end of the 26-week period, you must notify the Fund Office. If you receive benefits after recovering from your disability, you will be required to repay the Fund.

**If you retire**. You are no longer eligible for benefits as of the date of your retirement from the IUPAT or Affiliated Workers Union and Industry Pension Fund. If you continue receiving disability benefits after you retire, you will be required to reimburse the Fund.

**If you have successive periods of disability.** If you have two periods of disability that are separated by less than ten days of continuous employment or are due to related causes, then the two periods are considered one period of disability, and will count toward the same maximum 26-week period of disability payments.

### Exclusions

Benefits cannot be paid if:

- you are not under the regular care of a "qualified, licensed, professional" or not following the course of treatment prescribed,
- you have not provided proof of disability signed by your "qualified, licensed, professional",
- the Fund does not receive periodic updates from your "qualified, licensed, professional",
- you are eligible for benefits under Workers' Compensation,
- the injury was intentionally self-inflicted, or
- you are receiving a pension from the IUPAT.

**Questions? If you have any questions about weekly disability benefits, call the Fund Office at 215-934-5130.**

### Filing a Claim

To receive weekly disability benefits, you must file a claim for benefits with the Fund Office. For more information on claims, see the section called "Benefit Claim Determinations and Appeals." Written notice must be given to the Fund Office within thirty-one (31) days after the illness or injury occurs.

# LIFE INSURANCE

The Fund provides a life insurance benefit for Active Participants. Under this benefit your designated beneficiary will receive a lump-sum payment in the event of your death, from any cause, while you are covered by the Fund. This benefit is provided through Amalgamated Insurance Company ("Amalgamated").

**IMPORTANT: The actual insurance policy issued by Amalgamated is what controls the life insurance benefits offered under this Plan. If there is a conflict between the contents of this SPD and the insurance policy issued by Amalgamated, then the insurance policy shall control. You can contact the Fund Office if you would like to review a copy of the Amalgamated insurance policy.**

If you die while covered by the Fund, your designated beneficiary will receive a $30,000 life insurance benefit.

While the benefit is normally paid as a lump sum, it can, upon request, be paid in a different way such as a fixed time payment option, fixed amount payment option or an interest payment option. Please contact the Fund Office for additional information on the additional payment options.

## Your Beneficiary

When you enroll for Fund coverage, you will be asked to designate a beneficiary on your enrollment card. You may name any person you wish, and you may change your beneficiary at any time. If you do not designate a beneficiary or if your beneficiary dies before you, the benefit will be paid to the following surviving individual(s) in this order:

- your legal spouse,
- your children (including legally adopted children)* (in equal shares),
- your surviving parents (in equal shares),
- your surviving siblings (in equal shares), or, if none of the above
- your estate.

*Payments to your child(ren) may be made through your child(ren)'s legal guardian.

**You should review your beneficiary designation every year to make sure your choice is up to date. To change your beneficiary, you need to file a new beneficiary designation form with the Fund Office. Your change will not be effective until the Fund Office receives the form.**

## Continuation of Coverage During Disability

If you become "totally and permanently disabled" while covered by the Plan and before you reach age 60, your life insurance coverage will be extended.

"Totally and permanently disabled" means that a disabling illness or injury has prevented you from performing the main duties of your job for at least six continuous months (or less, if it can be presumed that you are permanently disabled).

### Required notice

To receive this extended life insurance coverage, you must notify the Fund Office of your disability within one year of the onset, and you must be disabled at the time you notify the Fund. Amalgamated may require that you have one or more medical examinations to verify your disability.

**Your extended coverage ends** if you fail to give proof of disability, you are no longer disabled, or you convert from group life insurance to individual whole life insurance.

### Converting to an Individual Policy

Generally, if your life insurance coverage ends for any reason, including losing coverage due to recovery from a disability, you may convert your group insurance to individual coverage. To convert to an individual policy, you must contact the Fund Office within 31 days from the date of termination so that you can complete the forms that must be submitted to Amalgamated. You are responsible for the cost of this coverage.

If your death occurs within 31 days after your group life insurance coverage ends, a benefit will still be paid to your beneficiary as long as your death certificate is provided to the Fund Office within one year after your death.

### Accelerated Benefit

The imminent death benefit is available if you have been diagnosed as having less than 12 months to live. Please contact the Fund Office for additional information on this benefit.

### Filing a Claim

Your beneficiary must provide the Fund Office with a certified copy of your death certificate. Written notice must be given to the Fund Office within thirty-one (31) days after the loss occurs, or as soon as reasonably possible. For information on filing claims and procedures to be followed to appeal a claim that is denied, see the section called "Benefit Claim Determinations and Appeals."

**Questions? If you have any questions about the life insurance benefit, you should contact the Fund Office at 800-252-7252 or 215-934-5130.**

# ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The Fund also provides a benefit in the case of accidental death or dismemberment. This benefit is available only to Active Participants, and is provided through an insurance policy purchased from Amalgamated Insurance Company ("Amalgamated").

**IMPORTANT: The actual insurance policy issued by Amalgamated is what controls the accidental death and dismemberment insurance benefits offered under this Plan. If there is a conflict between the contents of this SPD and the insurance policy issued by Amalgamated, then the insurance policy shall control. You can contact the Fund Office if you would like to review a copy of the Amalgamated insurance policy.**

## Death Benefit

The Fund will pay $30,000 to your beneficiary if you die as the result of an accident.

**Your beneficiary must submit a certified copy of your death certificate and request the death benefit in writing within one year of the date of your death**.

## Dismemberment Benefits

If you have an accident while covered under the Plan that results in any loss listed in the following schedule, you will receive the amount shown. The dismemberment must be due to a bodily injury that you received through external, violent, and accidental means.

## Schedule of Benefits

| For Loss of: | Benefit Amount |
|---|---|
| Two limbs (two feet or two hands) | $30,000 |
| Sight of both eyes | $30,000 |
| One limb and sight of one eye | $30,000 |
| One limb or sight of one eye | $15,000 |
| Speech or hearing | $7,500 |

Loss of a limb means severance at or above the wrist or ankle. Loss of sight means the total and irrecoverable loss of sight.

## Your Beneficiary

The beneficiary you name for your life insurance is also your beneficiary for AD&D benefits. For more information, see the section called "Naming a Beneficiary" in the life insurance section.

## Exclusions

AD&D benefits cannot be paid if your loss is caused by any of the following:

- Intentionally self-inflicted injuries while sane;
- Flight travel in any kind of aircraft, except as a fare paying passenger on a regularly scheduled commercial or charter flight;
- Bacterial infection;
- Participation in the commission of a felony crime;
- War or an act of war, or service in the armed forces of any country while such country is engaged in war;
- Disease or infirmity of the body or mind or from its medical or surgical treatment.

## How to File a Claim

You or your beneficiary should contact the Fund Office and submit a completed claim form and proof of the accidental death or dismemberment. You or your beneficiary must provide proof that the loss occurred as the result of accidental injury within thirty-one (31) days after the loss occurs, or as soon as reasonably possible.

See the section called "Benefit Claim Determinations and Appeals" for additional information on filing claims and procedures to be followed to appeal a claim that is wholly or partially denied.

# RETIREE BENEFITS

The Plan also provides benefits for eligible Retirees and their Eligible Dependents. (For information on Plan eligibility, see the section called "Eligibility and Participation.") Retiree hospital and medical benefits are provided through insurance policies purchased from Blue Cross/Blue Shield.

**IMPORTANT: The actual insurance policies are issued by Blue Cross/Blue Shield and control the retiree hospital and medical benefits offered under this Plan. If there is a conflict between the contents of this SPD and the insurance policies, then the insurance policies shall control. You can contact the Fund Office if you would like to review a copy of the insurance policies.**

- **If you are eligible for Medicare and you meet the requirements for Retiree coverage**, the Fund offers Medigap coverage and you will be required to pay for this coverage. For more information on Medicare and the Plan's coverage, see the following sections.

- **If you are <u>not</u> eligible for Medicare and you meet the requirements for Retiree coverage**, the Plan will continue to provide you with medical, prescription drug, dental, and vision benefits. However, you will be required to pay for this coverage. For more information, see the section called "Retirees Who Are Not Eligible for Medicare."

**More About Medicare**

If you are retired and age 65 or over, or if you are under age 65 and in receipt of a Social Security Disability Award, you are eligible to enroll in Medicare.

Medicare provides benefits as follows:

- **Part A** – provides inpatient hospital services, post-hospital extended care services, home health services and hospice care.

- **Part B** – provides doctors' services, outpatient hospital and a number of other health care services.

- **Part D**- provides prescription coverage. Individuals enrolled in the Fund's prescription plan do not need to enroll in a Medicare Plan Part D plan as the coverage provided under the Fund's plan is as creditable as the coverage provider through Medicare Part D. Please see the section entitled, "Medicare Part D Creditable Notice"

Medicare Part A is free. Medicare Part B is a voluntary program that requires monthly premium payments.

A Retiree must enroll in both Medicare Part A and Part B promptly when he becomes eligible in order to receive Fund coverage. To enroll in Medicare, visit an office of the Social Security Administration about three months before your 65th birthday.

If you have questions about your eligibility for Medicare, you can call the Social Security Administration toll free at 800-772-1213.

## When You are Eligible for Medicare

When you enroll in Medicare, you are no longer entitled to the Plan's regular benefit package. Instead, you become eligible for the "Medigap Plan", described below:

### MedigapSecurity — PLAN C

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD
*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| SERVICES | MEDICARE PAYS | PLAN C PAYS | WITH PLAN C, YOU PAY |
|---|---|---|---|
| HOSPITALIZATION*<br>Semiprivate room and board, general nursing, and miscellaneous services and supplies. | | | |
| First 60 days | All but $1,100 | $1,100 (Part A deductible) | $0 |
| 61st through 90th day | All but $275 a day | $275 a day | $0 |
| 91st day and after: | | | |
| • While using 60 lifetime reserve days | All but $550 a day | $550 a day | $0 |
| • Once lifetime reserve days are used: | | | |
| – Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0** |
| – Beyond the additional 365 days | $0 | $0 | All costs |
| SKILLED NURSING FACILITY CARE*<br>You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $137.50 a day | Up to $137.50 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| BLOOD | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| HOSPICE CARE<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN C *(continued)*

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR
†Once you have been billed $155 of Medicare-approved amounts for covered services (which are noted with a dagger), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN C PAYS | WITH PLAN C, YOU PAY |
|---|---|---|---|
| MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $155 of Medicare-approved amounts† | $0 | $155 (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| Part B Excess Charges (Above Medicare-Approved Amounts) | $0 | $0 | All costs |

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR
†Once you have been billed $155 of Medicare-approved amounts for covered services (which are noted with a dagger), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN C PAYS | WITH PLAN C, YOU PAY |
|---|---|---|---|
| BLOOD | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $155 of Medicare-approved amounts† | $0 | $155 (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| CLINICAL LABORATORY SERVICES — BLOOD TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

MEDICARE (PARTS A & B)

| SERVICES | MEDICARE PAYS | PLAN C PAYS | WITH PLAN C, YOU PAY |
|---|---|---|---|
| HOME HEALTH CARE MEDICARE-APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable medical equipment | | | |
| • First $155 of Medicare-approved amounts† | $0 | $155 (Part B deductible) | $0 |
| • Remainder of Medicare-approved amounts | 80% | 20% | $0 |

OTHER BENEFITS — NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | PLAN C PAYS | WITH PLAN C, YOU PAY |
|---|---|---|---|
| FOREIGN TRAVEL — NOT COVERED BY MEDICARE | | | |
| Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| • First $250 each calendar year | $0 | $0 | $250 |
| • Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

**Additional benefits.** In addition to the medical benefits provided, the Plan also provides you with prescription drug, dental, and vision care benefits. For a description of these benefits, see the sections that describe these benefits.

### Retirees Who Are Not Eligible for Medicare

If you retire before you become eligible for Medicare, you are eligible for continued medical, prescription drug, dental, and vision coverage. For descriptions of these benefits, see the appropriate sections.

**When you must begin to pay for coverage**. When you retire, your coverage will continue free of charge for six months. At the end of your period of free extended coverage, or when you turn 65 (if sooner), you must make the required payments to continue coverage for yourself and your dependent(s). It's your responsibility to make the payments on time.

If you do not pay for continued coverage before you enroll in Medicare, then generally you cannot return to the Fund for supplemental coverage when you become eligible for Medicare. However, if you are eligible for coverage under another plan, you may waive your continued coverage under this Plan, as long as you provide the Fund with proof of coverage under another employer sponsored group health plan. Provided you give the Fund proof of other coverage, you can return to the Fund for supplemental coverage when you become eligible for Medicare.

**When you become eligible for Medicare,** your benefits will convert to the Medigap Plan on the respective dates when you and your spouse become entitled to Medicare, provided you pay the required monthly premium.

### Dependent Coverage

When they become eligible for Medicare, your dependents are also entitled to the Medigap Plan. If, after you retire, your dependents are not eligible for Medicare, they will continue to receive medical, prescription drug, dental, and vision benefits through the Fund's pre-Medicare benefit programs for retirees, provided they fulfill all Plan eligibility requirements and you timely pay appropriate premiums for such coverage.

### Payment for Retiree Coverage

When you retire, the Fund will notify you when your self-payment is due. You will also be notified if the Board of Trustees changes the rate.

### How to Claim Benefits

For information on filing claims, please refer to the section called "Benefit Claim Determinations and Appeals."

### Continuation of Benefits

Like other Fund benefits, retiree benefits are subject to change or termination at any time, in the sole and absolute discretion of the Board of Trustees.

The Fund recommends that you contact the Social Security Administration at least three months before you reach age 65 to sign up for both Medicare and Social Security retirement benefits. Once you receive your Medicare card, you must forward a copy to the Fund Office.

**If you have any questions about retiree coverage, you should contact the Fund Office at 800-252-7252 or 215-934-5130.**

If you have questions about Medicare, you should contact the Social Security Administration 800-772-1213. In addition, you can get much information on Medicare, and the optional arrangements now available under Medicare, at the website **www.Medicare.gov**.

# COORDINATION OF BENEFITS

Our Plan has a coordination of benefits (COB) provision. This provision ensures that if you or an Eligible Dependent is covered by another group medical plan, benefits from all plans combined will not exceed 100% of the maximum allowable expense provided for under this plan.

You must report other group health insurance coverage you have on the claim form that you submit when you claim benefits. To assure proper coordination of benefits, the Board of Trustees reserves the right to:

- Exchange information with other parties
- Make payments to other parties in satisfaction of Plan liabilities, and
- Recover any excess payments made, including offsetting such payments against future benefits.

**Which Plan Pays First**

If you are covered by two plans and the other plan does not have a coordination of benefits provision, the other plan will always pay its benefits first, before this Plan pays any benefits.

However, if **both** plans have COB provisions, benefits will be paid in the following order:

- **Employee/dependent rule.** The plan covering an individual as an employee is primary (i.e., pays first) and the plan covering an individual as a dependent is always secondary (i.e., pays second).
- **Birthday rule.** For dependent children of parents who are not legally separated or divorced, the plan of the parent whose birthdate (month and day, not year) falls earlier in the calendar year is primary and the plan of the parent whose birthday falls later is secondary.
- **Father rule.** If the other plan does not have a birthday rule, the plan covering the dependent's father is primary.
- **Children of separated/divorced parents rule**. For dependent children of parents who are separated or divorced, the plan of the parent with custody is the primary plan; the plan of a stepparent (spouse of parent with custody) is the secondary plan; and the plan of the parent without custody is tertiary (i.e., pays third). However, if a court decree (such as a Qualified Medical Child Support Order, or "QMCSO") designates one parent as responsible for medical expenses, then benefits will be paid according to that decree.
- **Longer/shorter rule.** For situations not governed by the above rules, the plan that has covered the individual longer is the primary plan and the plan that has covered the individual for less time is secondary.
- **Medicare**. When you reach age 65 or become disabled, you are eligible for hospital benefits (Part A) and supplemental medical benefits (Part B) under Medicare. If you are a

retiree, Medicare is the primary plan, and this plan is secondary. Otherwise, this plan is primary and Medicare is secondary.

Medicare covers any charges for services related to end-stage renal disease subject to certain rules, but the Fund covers all other charges.

**You must enroll in Medicare promptly. This Plan does not cover any expenses Medicare would have covered if you had enrolled on time. To enroll in Medicare, visit an office of the Social Security Administration about three months before your 65th birthday.**

**Whether or not you enroll in Medicare, the Plan will only pay expenses as if you had enrolled in Medicare.**

**Coordination procedures.** If you and your spouse are covered by separate plans, you should follow these procedures:

- If your **spouse** incurs medical expenses, a claim should be filed with his or her plan. After that claim is settled, there may be additional out-of-pocket costs (for example, deductibles and copays). You may then file a claim with this Plan, including a copy of the original claim filed with your spouse's plan and the explanation of benefits. The unreimbursed portion of the claim will be considered for reimbursement, subject to Plan provisions.
- If your **dependent child** incurs medical expenses and your birthday falls earlier than your spouse's (and thus, generally **this Plan would be primary**), a claim should first be filed with this Plan. If there is any unreimbursed amount, you may file a claim with your spouse's plan, and include the explanation of benefits provided from this Plan. The unreimbursed portion of the claim will be considered for reimbursement, subject to that plan's provisions.
- If your **dependent child** incurs medical expenses and your birthday falls later than your spouse's (and thus, generally **your spouse's plan would be primary**), a claim should first be filed with your spouse's plan. If there is any unreimbursed amount, you may file a claim with this Plan, and include the explanation of benefits provided from your spouse's plan. The unreimbursed portion of the claim will be considered for reimbursement, subject to this Plan's provisions.
- If **you** (as a Plan participant) have incurred medical expenses, you should first file a claim with this Plan. Once this claim has been settled, if there are any unreimbursed amounts (such as deductibles or copays), you may then file a claim with your spouse's plan, including a copy of the original claim and the explanation of benefits. The unreimbursed amount will then be considered for reimbursement subject to the provisions of your spouse's plan.

Last, in no event will the amount paid from this Plan, when combined with the amount paid from any other insurance, exceed 100% of the Plan's benefit. Similarly, if this Plan is secondary, then its liability is further limited to the lesser of the participant's liability or what the primary plan paid on the claim.

# BENEFIT CLAIM DETERMINATIONS AND APPEALS

## Claims for Benefits Paid by the Plan (Self-Insured Benefits)

The Board of Trustees makes the decisions on employee benefit eligibility and on claims for benefits paid by the Plan. The time in which you will be notified of the Plan's decision with regard to claims paid by the Plan (self-insured claims) depends upon the type of treatment or services to which your claim relates as explained below.

## Claims for Benefits Paid by Insurance Carriers

Decisions on claims for benefits paid by an insurance carrier are made by the insurance carrier in accordance with the provisions of the insurance contract. You should review the booklet you receive from the insurance carrier for detailed claims and appeals procedures. The insurance carrier is subject to federal law requirements regarding benefit claim determinations and appeals with respect to Urgent Care, Concurrent Service, Pre-Service, and Post-Service Claims. You should file an appeal with the insurance carrier and copy the Fund on the appeal if these requirements are not satisfied.

## Urgent Care Claims

An urgent care claim is involved if, in the opinion of your physician, you would be subject to severe, unmanageable pain absent the care or treatment for which you are claiming coverage. An urgent care claim is also involved if your life or health would be seriously jeopardized if the Plan's determination with respect to your claim were made in the time period allowed for non-urgent treatment decisions.

If your claim involves urgent care, you will be notified of the Plan's decision (adverse or not) as soon as possible taking into consideration your particular medical circumstances, but no later than 72 hours after the claim has been received unless the claimant (or the representative of the claimant) fails to provide sufficient information to determine whether or to what extent, benefits are covered or payable by the Plan.

If more information regarding your claim is needed, or if you fail to follow the Plan's procedures for filing a claim, the Fund Office will request this information or notify you of such failure no later than 24 hours after the claim is received. You will then have 48 hours in which to produce the requested additional information. You will be notified of the Plan's decision no later than 48 hours after the earlier of the Plan's receipt of the information or the end of the period for supplying the additional information.

## Claims Involving Concurrent Care/Ongoing Treatment

Concurrent care decisions are those that are made in connection with an approved course of treatment that is provided over a period of time or through a number of treatments. You will be notified by the Fund Office of any reduction or termination of such treatment or care with

sufficient time to allow you to appeal the reduction or termination before it is implemented. Any such reduction or termination will be considered a claim denial (except when a Plan amendment or termination causes the reduction or termination of the treatment or care).

You may request that a course of treatment be extended beyond the approved time period or number of treatments. If your concurrent care claim involves a request to extend treatment for urgent care, you will be notified of the Plan's decision (adverse or not) as soon as possible but no later than 24 hours prior to the expiration of the treatment period or number of treatments (provided your claim is submitted to the Plans no later than 24 hours prior to the expiration of the prescribed period of time or number of treatments).

**Pre-Service Claims**

A pre-service claim is one that conditions receipt of a benefit on advance approval prior to obtaining medical care. If you fail to follow the Plan's procedures for filing pre-service claims, you will be notified by the Plan of the failure and the proper procedures within 5 days following the failure (24 hours in the case of a failure to file a claim involving urgent care). This notification may be oral unless you or your authorized representative has requested written notice.

You will be notified of the Plan's decision regarding a pre-service claim (adverse or not), within a reasonable period of time taking into consideration your particular medical circumstances, but no later than 15 days after receipt of the claim by the Plan.

An additional one-time extension of up to 15 days is allowable for matters beyond the control of the Plan, such as insufficient information submitted with your claim. You will be notified of any extension within 15 days from the date the claim was originally filed. The notice will state the reason for the extension and the date by which the Plan expects to make a decision. If the extension is required due to your failure to submit information necessary to decide the claim, the notice of extension will describe the required information. If additional information is necessary, you will have 45 days to supply the Fund Office with the missing information.

**Post-Service Claims**

Post-service claims are those claims which are not urgent care claims or pre-service claims. You will be notified of any adverse decision by the Plan with regard to a post-service claim within a reasonable period of time, taking into account your particular medical circumstances, but no later than 30 days after receipt of the claim by the Plan.

A one-time extension of up to 15 days is allowable for matters beyond the control of the Plan, such as insufficient information submitted with your claim. You will be notified of any additional extension, including the reason why the extension is necessary, a description of any information necessary to complete your claim, and the date by which the Plan expects to make a decision, within 30 days from the date the claim was originally filed. If the extension is due to

insufficient information submitted with your claim, you will have 45 days to supply the Fund Office with the missing information.

**Disability Benefit Claims**

You will be notified of any adverse decision by the Plan with regard to disability benefits within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days provided that the extension is necessary due to matters beyond the control of the Plan and the Plans notifies you prior to the expiration of the initial 45-day period.

If, prior to the end of the first 30-day extension, the Plan determines that, due to matters beyond the control of the Plan, a decision cannot be made within that extension period, the Plan may take another 30-day extension.

In each extension notice, the Plan must notify you of the reason(s) for the extension and the date on which the Plan expects to make a decision. This notice will also explain the standards used by the Plan in determining whether a participant is entitled to a disability benefit, the unresolved issues preventing a decision on your claim, and any additional information needed to resolve those issues. If the Plan cannot make a determination because it needs additional information from you, you will have 45 days in which to provide the additional information.

**Manner and Content of Notification of Health and Welfare Benefit Determination**

In the case of an adverse benefit determination, the Plan will provide you (or your authorized representative) with written notification of the denial written in a manner you should be able to understand. The notification will include the following:

- The specific reasons for the adverse determination;
- Reference to the specific Plan provision(s) on which the determination was based;
- A description of any additional material or information necessary to perfect (complete) the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on review;
- If an internal rule, guideline, protocol, or other criterion was relied upon in making the adverse determination, either (1) a copy of such rule, guideline, protocol or other criterion or (2) a statement that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request;
- If the adverse benefit determination was based on medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical

judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request;

- In the case of an adverse benefit determination involving a claim for urgent care, a description of the expedited review process applicable to such claims will be provided. The information may be provided to the claimant orally within the time-frame prescribed, provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

## Appealing a Denied Claim

An adverse benefit determination is any decision by the Plan to deny, reduce, terminate, or refuse payment for a benefit.

The Board of Trustees makes the final decisions on employee benefit eligibility and on claims for benefits paid by the Plan. Final decisions on claims for benefits paid by an insurance carrier are generally made by the insurance carrier in accordance with the provisions of the insurance contract.

If you disagree with the final decision on appeal, you may file a lawsuit seeking your benefit under ERISA. Courts require that you complete all the steps available to you under the Plan's claims procedure in a timely manner before you seek relief through a lawsuit against the Plan. This is called "exhausting your administrative remedies."

## Hospital and Medical Benefit Appeals

If you disagree with a hospital or medical benefit decision you should appeal to appropriate insurance carrier. i.e. Capital Blue Cross. You should consult your specific Summary Plan Description to determine the procedures you must follow in order to exhaust your administrative remedies against the insurance carrier.

## Plan Appeals

You (or authorized representative) will have 180 days after receiving notice that his/her claim for eligibility or self-insured benefits is denied to appeal the decision in writing to the Board of Trustees at the Fund Office. You (or your authorized representative) have the right to submit comments, documents, records, and other information relevant to the claim. You (or your representative) have the right to review all official documentation relating to the Plan and, in addition, you will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.

Any appeal that does not involve urgent care must be in writing, and can be made by you or a duly authorized representative. The appeal must set out the reasons for the appeal and your

dissatisfaction or disagreement with the Plan's decision. Any evidence, comments, or documentation to support your position should be submitted with your written appeal.

A claim review on appeal will not afford deference to the initial adverse benefit determination. The review will be conducted by an appropriately named fiduciary who is neither the individual nor subordinate to the individual who made the initial adverse determination. All comments, documents, records, and other information submitted by the claimant relating to the claim will be considered on appeal, regardless of whether or not such information was submitted or considered in the initial adverse benefit determination.

If an appeal involves medical judgment, including determinations with regard to medical necessity and whether a particular treatment, drug, or other item is experimental or investigational, the Board of Trustees will consult with an independent health care professional with appropriate training and experience in the field of medicine involved. This health care professional will be someone who was neither an individual who was consulted in the initial adverse benefit determination or the subordinate of such individual. All medical or vocational experts whose advice was obtained in the initial adverse benefit determination will be identified by the Board of Trustees, regardless of whether or not the individual's advice was relied upon in making the initial adverse benefit determination.

The Fund Office may request additional information to clarify any matters it deems appropriate. The time period in which the Board of Trustees will review your appeal and notify you of its decision varies depending on the type of treatment or services to which your appeal relates as explained below:

**Appeals of Urgent Care Claims**

You will be notified of a decision on appeal with respect to a claim involving urgent care as soon as possible but no later than 72 hours after the appeal request has been received by the Plan. In order to expedite the appeals process for urgent care claims, you may submit a request for an appeal involving urgent care orally, and all information with respect to the claim may be transmitted by telephone, facsimile, or other available similarly expeditious method.

**Appeals of Pre-Service Claims**

You will be notified of a decision on appeal with respect to a pre-service claim within a reasonable period of time but no later than 30 days after the appeal request has been received.

**Appeals of Post-Service and Disability Claims**

The Board of Trustees normally will consider an appeal of a post-service or disability claim determination at their regular meeting scheduled at least 30 days after the appeal is received. Consideration can be delayed to the following meeting if the request for review is filed within 30 days preceding the date of such meeting. In that case, a determination may be made no later than the date of the second meeting following the Plan's receipt of the request for review.

If special circumstances require a further extension of time for processing, a benefit determination shall be made not later than the third meeting of the Board following the Plan's receipt of the review request. If an extension of time for review is required due to special circumstances, you will be notified in writing of the extension, with a description of the special circumstances and the date the determination will be made, prior to the commencement of the extension. You will be notified of the Board of Trustees' decision on the appeal in writing as soon as possible but not later than 5 days after the determination is made.

**Notification of Benefit Determination on Review**

The Plan will provide you with written or electronic notification of the Board of Trustees' decision on review. In the event your appeal is denied, this notice will include the following:

- The specific reason(s) for the denial;
- Reference to the specific Plan provision(s) on which the decision was based;
- A statement that the claimant will be 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 for benefits;
- A statement regarding the claimant's right to bring a civil action in court;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- If the adverse benefit determination is based on medical necessity, experimental treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

You and the Plan may also have the right to other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

If the Plan fails to follow the claims appeals procedures as outlined above, you will have the right to bring a civil action in court.

# THIRD PARTY LIABILITY

## BACKGROUND

The Health and Welfare Fund ("Fund") exists to pay accident and sickness or other benefits, when you (or an Eligible Dependent) are injured or become ill, as provided in this Plan of Benefits ("Plan"). Because the Fund's assets are limited, however, the Fund is not obligated to provide benefits for an illness, injury or condition regarding which another party might be liable to you for damages or liable or otherwise required to provide benefits. Thus, while the Fund may advance benefits in such circumstances, it retains the right to be reimbursed for such benefits by you or an appropriate third party, on a first dollar basis, as set forth here and below.

An example may make this clear: imagine you are injured accidentally at a local business, and miss work as a consequence. You apply for and receive weekly disability benefits from the Fund while you are out of work. Thereafter, you decide to sue the business to recover for the injuries you suffered. Should you recover in this "third party" lawsuit, you must reimburse the Fund, on a first dollar basis - that is, you must reimburse the Fund from the first dollar you receive - any and all the benefits the Fund distributed to you under the Plan of Benefits.

Set forth in this section are the details of the Fund's rights to reimbursement and"subrogation," and your responsibilities as a Participant or Beneficiary. You also may be asked to sign an acknowledgment and agreement as a condition of receiving benefits, in order to confirm your agreement to and your understanding of the Fund's rights and your responsibilities. Please remember, the purpose of this portion of the Plan of Benefits is to ensure that the Fund's limited funds are not used to provide benefits where other sources of such benefits or compensation may be available.

## THE FUND'S RIGHTS

1. RIGHT OF SUBROGATION: When the Fund, or any of the insurance carriers which provide benefits under the Plan, pays or provides any benefits for you or your Eligible Dependent under the Plan, the Fund is "subrogated" to all rights of recovery the law may provide to you or your Eligible Dependent, regardless of their source in the law -- contract, tort or otherwise -- against any person, individual, entity, organization or corporation that you could sue for the benefits or compensation that the Fund has paid or provided to you. This means that the Fund may step into your shoes to use your legal right (or your Eligible Dependent's legal right) to sue and recover damages or benefits to reimburse itself first, and before any other amounts are paid to you, for benefits provided to you by the Fund.

2. RIGHT OF REIMBURSEMENT: In addition to a right of subrogation, the Fund retains a separate right to be repaid **in full** (in an amount not to exceed the amount of either the benefits provided by the Fund or the amount of your recovery) from any money a Participant or Beneficiary recovers for which the Fund has provided plan benefits. This means that Participants and Beneficiaries must repay the Fund **first dollar** the amount the Fund has paid or provided in plan benefits from any money recovered from a third party (whether by judgment, settlement,

lien or otherwise), even if the recovery is for (or said to be for) a loss other than that for which the Participant or Beneficiary received benefits from the Plan (such as pain and suffering, punitive damages, mental anguish, "special" or any other type of damages), and even if the Participant or Beneficiary does not recover in full on his or her claims. If one is paid by a third party's insurer or one's own insurer (including any underinsured and uninsured auto insurance), one must repay the Fund in full.

3. EQUITABLE LIEN: You or your eligible Dependent must repay to the Fund the benefits paid on your behalf out of the amounts recovered from the other person or their insurance company, benefits plan or any other organization. The Fund's right of reimbursement applies even if you or your Dependent's claims are settled without an admission of fault and even if you or your eligible Dependent recover or have the right to recover no- fault insurance benefits. **The Fund has a lien on any amount recovered by you or your eligible Dependent, regardless of whether the amount is designated as payment for medical expenses. The Fund's lien arises through operation of the Plan. No additional reimbursement agreement is necessary.** This lien will remain in effect until the Fund is reimbursed in full.

4. CONSTRUCTIVE TRUST: If you (or your attorney or other representative) receive any payment through a judgment, settlement or otherwise - for an illness or injury that is caused by a third party, you agree to maintain the funds in a separate, identifiable account and that the Fund has an equitable lien on the funds. In addition you agree to serve as a constructive trustee over the funds to the extent that the Fund has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds, and responsible for them to the Fund.

5. REJECTION OF MAKE WHOLE DOCTRINE: The Plan explicitly rejects and disclaims the "make whole" doctrine. This means that the Fund's rights do not depend upon a Participant's (or Beneficiary's) first being made "whole," or receiving all compensation to which he or she might be entitled.

6. RIGHT TO SET OFF: In the event that the Participant fails or refuses to comply with the terns of the Plan, then the Fund, in addition to any other rights to which it or its Trustees may have, shall have the right to withhold from any payments due or that become due to the Participant (or his or her Beneficiary), or to any third parties on behalf of the Participant (or Beneficiary) from the Fund, any amount necessary until the Fund is fully reimbursed as described herein. As a condition of receiving any benefits, Participants (and Beneficiaries) must acknowledge and agree to this right of set off and cooperate with the Fund when it requests information about possible subrogation or reimbursement issues. The Fund may also bring a lawsuit against a Participant, or Beneficiary to collect on payments already made.

**PARTICIPANT'S (or Beneficiary's) OBLIGATIONS:**

DISCLOSURE: In order to receive benefits, a Participant or Beneficiary must:

- Notify the Fund in writing that a Claim relating to such illness or injury has been filed by the Participant or Beneficiary against a third party seeking available funds, and must

assist fully and cooperate with the Fund in protecting the Fund's reimbursement and subrogation rights;

- Notify the Fund in writing of the name and address of the Participant's (or Beneficiary's) attorney, provide that attorney with a copy of the Plan and the executed Acknowledgment and Agreement form, and require the attorney to comply with the Plan's terms;
- Keep the Fund informed in writing of the progress and/or settlement of the claim;
- Include in all claims a claim for benefits paid (or to be paid) by the Fund to and/or on behalf of the Participant or Beneficiary, plus interest accruing from the date of payment of such benefit and refuse any settlement or resolution of a claim until the Fund has authorized the settlement;
- Reimburse the Fund in full for any benefits paid by the Fund to or on behalf of the Participant or Beneficiary, plus interest accruing from the date of payment of such benefits; and
- Require and authorize the attorney to withhold from available funds any monies due the Fund, and to forward the monies to the Fund. In case of any dispute over what monies are due the Fund, the available funds are to be escrowed pending resolution of the dispute.

ELIGIBLE DEPENDENTS: Any Participant making a claim on behalf of an Eligible Dependent under the Fund's plan shall make an acknowledgment and agreement on behalf of the Eligible Dependent and warrants that the Participant is authorized to make such an acknowledgment and agreement on behalf of the Eligible Dependent.

**OTHER MATTERS**

OTHER INSURANCE: Any payment received by the Participant from any insurance carrier, from Blue Cross, Blue Shield or from any like or similar carrier, for which the Participant has paid the full premium in order to secure individual coverage (as distinguished from group coverage), shall be excluded from the requirements of reimbursement.

ASSIGNMENT OF RIGHTS OR BENEFITS: The Participant cannot assign, encumber, pledge or otherwise alienate any legal or beneficial interest provided under the Fund and any attempt to do so will be void.

ATTORNEYS' FEES: The Fund will **not** reimburse you, as a Participant, or your Eligible Dependent for any attorneys' fees incurred while pursuing any third party claim, even if you are successful in your claim (whether by settlement, judgment, lien or otherwise). The Fund expressly disavows the "common fund" and "collateral source" doctrines and any other judicial doctrine that would impose fee splitting between the Fund and the Participant's (or Beneficiary's) attorneys. The Fund's lien includes attorney's fees and the costs of collection.

SCOPE OF RIGHTS: These subrogation and reimbursement provisions will be interpreted by the Trustees, in their sole and final discretion, to permit the Fund to obtain full satisfaction of any lien or right to reimbursement from you or your eligible Dependent or any other person who received payment on your behalf (including, but not limited to, a parent,

spouse, guardian or estate). The Trustees may, in their sole discretion, allocate the responsibility for reimbursement or satisfaction of a lien among you, your eligible Dependent, and any other person, such as your or your eligible Dependent's legal counsel.

RIGHT TO RECEIVE AND RELEASE INFORMATION: Subject to the Trustees' obligations under Health Insurance Portability and Accountability Act of 1996 or any other applicable law, for the purpose of implementing these subrogation and reimbursement provisions, the Trustees or Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company, other organization or person any information that the Trustees or Administrator regard as necessary, with respect to you or your eligible Dependent claiming benefits under this Fund. When you are claiming benefits under this Fund, you or your eligible Dependent must furnish to the Trustees or Administrator the information needed to enforce the subrogation and reimbursement provisions.

# IMPORTANT INFORMATION ABOUT THE WELFARE FUND

The Employee Retirement Income Security Act of 1974 (ERISA) requires that participants in employee benefit plans receive certain administrative information about their plans and the people who run them. Our Plan is subject to those rules and this section will tell you more about Plan operations.

**Name of Plan.** The Plan's formal name is the IUPAT District Council No. 21 Welfare Fund.

**Board of Trustees.** The Board of Trustees and/or its duly authorized designee(s) has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan, including this booklet, the Trust Agreement and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Fund or Trust.

All determinations and interpretations made by the Board of Trustees and/or its duly authorized designee(s) shall be final and binding upon all participants, beneficiaries and any other individuals claiming benefits under the Plan. The Board of Trustees may delegate such duties or powers as it deems necessary to carry out the administration of the Plan.

The Board of Trustees also reserves the right in its sole and absolute discretion to amend or terminate the Plan at any time and for any reason. Continuation of benefits is not guaranteed. Neither you, your beneficiaries nor any other person has or will have a vested or nonforfeitable interest in the Plan. In the event of the Plan's termination (which might occur if the Union and the employers negotiate the discontinuance of contributions or if the contributions called for by the collective bargaining agreements are insufficient to allow the Plan to continue), the Board of Trustees will apply the monies in the Fund to provide benefits or otherwise carry out the purpose of the Plan in an equitable manner until the Fund assets have been disbursed. In no event will any part of the Fund's assets revert to the employers or to the Union.

**Plan Sponsor and Administrator.** The Board of Trustees is the Plan Sponsor and the Plan Administrator.

**Identification Numbers.** The "employer identification number" assigned to the Fund by the Internal Revenue Service is 91-2036994. The plan identification number assigned to the Plan by the Board of Trustees, pursuant to IRS instructions, is 501.

**Plan Year.** Plan records are kept on a "Plan Year" basis, which is May 1 to April 30.

**Type of Plan.** Our Plan is known as a "welfare" plan under ERISA. It provides hospital, medical, prescription drug, vision, dental, weekly disability, life insurance, and accidental death and dismemberment benefits.

**Agent for Service of Legal Process.** In the event of a legal dispute involving the Plan, legal documents may be served on Fund Co-Counsel as follows:

John A. Adams, Esq.
Susanin, Widman & Brennan
Executive Terrace, 455 South Gulph Road, Suite 240, King of Prussia, PA 19406

Bruce Endy, Esq.
Spear, Wilderman, Borish, Endy, Spear & Runckel
230 South Broad Street, Suite 1400, Philadelphia, PA 19102

Legal process may also be served upon the Board of Trustees at the Fund Office address.

**Collective Bargaining Agreement/Contributing Employers.** The Fund is established and maintained in accordance with one or more collective bargaining agreements. A copy of any such agreement(s) may be obtained upon written request to the Fund Office, and is available for examination during normal business hours at the Fund Office. In addition, a complete list of the employers participating in the Fund may be obtained upon written request to the Fund Office and is available for examination by participants and beneficiaries during normal business hours at the Fund Office. The Fund Office may charge a reasonable amount for copies.

Participants and beneficiaries may also receive from the Fund Office, upon written request, information as to whether a particular employer or employee organization is participating in the Fund and, if the employer or employee organization is participating, its address.

**Source of Contributions.** The benefits described in this booklet are provided through employer contributions and, in some cases, employee contributions. The amount of employer contributions and the employees on whose behalf contributions are made are determined by the provisions of the applicable collective bargaining agreements. The Fund Office will provide, upon written request, information as to whether a particular employer is contributing to the Fund on behalf of employees.

**Trust Fund.** All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants, either through the direct payment of benefits or the payment of premiums to entities that insure these benefits, and defraying reasonable administrative expenses.

**Identification of insurance companies and other entities guaranteeing benefits.** Hospital and medical benefits are insured through various insurance contracts; and life and accidental death and dismemberment insurance benefits are guaranteed by Amalgamated Life Insurance. Contact information for all of these entities appears at the end of this booklet.

**Self-funded benefits.** Currently, the following benefits are self-funded: prescription drug benefits (administered by Express Scripts); dental benefits (administered by Fidelio), vision benefits (administered by National Vision Administrators), and weekly disability benefits (administered by the Fund Office). This means that benefits are paid directly out of Fund assets, rather than through an insurance policy. However, for some of these benefits, the Fund has contracted with an insurance company to administer these benefits – process claims, etc. All third party administrators are described in the back of the booklet.

# YOUR RIGHTS UNDER ERISA

As a participant in the IUPAT District Council No. 21 Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act Of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

- Examine, without charge, at the Fund Office and at other specified locations, such as work locations and union halls, all documents governing the Plan, including summary plan descriptions, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series).

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Trustees are required by law to furnish each participant with a copy of this summary annual report.

**Continue Group Health Plan Coverage**

- Continue health 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.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

**Prudent Actions by Plan Fiduciaries**

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

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

## Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents 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 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 (formerly the Pension and Welfare Benefits Administration), 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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# HIPAA PROTECTED HEALTH INFORMATION

## Definition of Protected Health Information

Protected Health Information ("PHI") shall mean the same as that term is defined in Section 164.501 of the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") issued by the Department of Health and Human Services ("HHS") and promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## Purpose

This section permits the Fund to disclose PHI to the Board, acting solely in its capacity as the sponsor of the Fund and not as the administrator of the Fund, to the extent that such PHI is necessary for the Board to carry out its administrative functions related to the Fund.

## Disclosure to the Board of Trustees

The Fund (or health insurance issuer or HMO with the Fund's permission) may disclose the PHI to the Board of Trustees that is necessary for the Board to carry out the following functions related to the Fund. The Board needs to access Covered Member's claim information for the purpose of performing those functions that are designated as "Plan Sponsor" functions under ERISA. Such functions include obtaining premium bids from health plans for providing health insurance coverage under the Fund and modifying, amending, or terminating the Fund or any benefit provided by the Fund. All other access to PHI by the Board is done in the Board's capacity as the administrator of the Fund and is described in the HIPAA Policies and Procedures for the Fund. The Board may use and disclose the PHI provided to it from the Fund (or health insurance issuer or HMO) only for the purposes described in this paragraph.

## Conditions on the Use and Disclosure of PHI

The Board agrees to the following conditions on use and disclosure of PHI received from the Fund:

(a) *Prohibition on Unauthorized Use or Disclosure of PHI.* The Board will not use or further disclose any PHI received from the Fund, except as permitted in this document or required by all applicable law, including but not limited to HIPAA.

(b) *Minimum Necessary Standards.* The Board will make reasonable effort to limit the PHI used, disclosed, or requested to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request.

(c) *Subcontractors and Agents.* The Board will require each of its subcontractors or agents to whom it provides PHI to agree to the same conditions that apply to the Board with respect to such information.

(d) *Permitted Purposes.* The Board will not use or disclose PHI for employment-related actions and decisions or in connection with any other of the benefits sponsored by the Board.

(e) *Reporting.* The Board will report to the Fund any impermissible or improper use or disclosure of PHI not authorized by the plan documents.

(f) *Access to PHI by Covered Persons.* The Board will make PHI available to the Fund to permit Covered Persons to inspect and copy their PHI contained in the designated record set.

(g) *Correction of PHI.* The Board will make a Covered Person's PHI available to the Fund to permit Covered Persons to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and will incorporate amendments provided by the Fund.

(h) *Accounting of PHI.* The Board will make a Covered Person's PHI available to permit the Fund to provide an accounting of disclosures.

(i) *Disclosure to Government Agencies.* The Board will make its internal practices, books and records relating to the use and disclosure of PHI received from the Fund available to the Department of Health and Human Services or its designee for the purpose of determining the Fund's compliance with HIPAA.

(j) *Return or Destruction of PHI.* When PHI is no longer needed for the purpose for which disclosure was made, the Board must, if feasible, return to the Fund or destroy all PHI that the Board received from or on behalf of the Fund. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Board agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

**Adequate Separation.** The Board represents that adequate separation exists between the Plan and Plan Sponsor. Only the Board will have access to the PHI provided by the plan and only for plan administration functions described above.

**Reports of Non-Compliance.** Anyone who suspects an improper use or disclosure of PHI may report the occurrence to the Fund's Privacy Official. The Fund and the Board will cooperate to remedy the situation and mitigate any harmful effect resulting from the use or disclosure of PHI. After an investigation into the incident, those employees who are found to be in violation of these policies or the HIPAA Privacy Regulations will be sanctioned as is deemed appropriate. The Fund and the Board will cooperate to create new safeguards and procedures so as to prevent a future incident of non-compliance.

**Certification.** The Fund will disclose PHI to the Board only upon receipt of Certification by the Board that the Board will protect the PHI as described in this section.

**Security of Protected Health Information**

Definition of Electronic Protected Health Information

The Security Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") provides procedures to safeguard your "Electronic Protected Health Information". "Electronic Protected Health Information" is defined in government regulations and generally is any Protected Health Information that is created, received, maintained, or transmitted in electronic form. The security requirements of this Section are effective April 21, 2005. If any other provision(s) of this booklet conflicts with the requirements of this Section, this Section will control.

Disclosure to Board of Trustees

The Board of Trustees and Plan will safeguard Electronic Protected Health Information by:

(a) *Administrative, Physical, and Technical Safeguards.* Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information the Board creates, receives, maintains, or transmits on behalf of the Plan.

(b) *Security of Adequate Separation.* Ensuring that the "adequate separation" between the Plan and other offices or plans of the Union or employers described in the "Privacy of Protected Health Information" section is supported by reasonable and appropriate security measures.

(c) *Subcontractors and Agents.* Ensuring that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information.

(d) *Reporting.* Reporting to the security official of the Plan or the security official's designee any Security Incident of which it becomes aware.

Exceptions

The requirements in Items 1 through 4 above do not apply to Electronic Protected Health Information that the Board of Trustees; (1) receives pursuant to an appropriate authorization that complies with HIPAA regulations or that qualifies as "Summary Health Information" and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending, or terminating the Plan as authorized by the HIPAA Privacy Rules. Summary Health Information is defined in HIPAA regulations and generally is claims data for the Plan from which most information that could be used to identify you individually is removed.

## NOTICE OF HEALTH PLAN'S PRIVACY PRACTICES

THE FOLLOWING DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**USE AND DISCLOSURE OF HEALTH INFORMATION**

The International Union of Painters and Allied Trades District Council No. 21 Welfare Fund ("Plan") may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

**To Make or Obtain Payment**. The Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

**To Conduct Health Care Operations**. The Plan may use or disclose health information for its own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all of the Plan's Covered Persons. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.

## NOTICE OF HEALTH PLAN'S PRIVACY PRACTICES

- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Plan, including customer service and resolution of internal grievances.

**For example, the Plan may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.**

**For Treatment Alternatives**. The Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**For Distribution of Health-Related Benefits and Services.** The Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

**For Disclosure to the Plan Sponsor.** The Plan may disclose your health information to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of the Plan. In addition, the Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan. The Plan also may disclose to the plan sponsor information on whether you are participating in the health plan.

**When Legally Required.** The Plan will disclose your health information when it is required to do so by any federal, state or local law.

**To Conduct Health Oversight Activities**. The Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

**In Connection With Judicial and Administrative Proceedings**. As permitted or required by state law, the Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

**For Law Enforcement Purposes**. As permitted or required by state law, the Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

# NOTICE OF HEALTH PLAN'S PRIVACY PRACTICES

**In the Event of a Serious Threat to Health or Safety**. The Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

**For Specified Government Functions**. In certain circumstances, federal regulations require the Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

**For Worker's Compensation**. The Plan may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

## AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Plan will not disclose your health information other than with your written authorization. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

## YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Plan maintains:

**Right to Request Restrictions**. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Plan's disclosure of your health information to someone involved in the payment of your care. However, the Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact: Benefits Coordinator at International Brotherhood of Painters and Allied Trades District Council NO.21 Welfare Fund, 2980 Southampton-Byberry Road, Philadelphia PA 19154 or by fax to (215) 677-3877.

**Right to Receive Confidential Communications**. You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to Benefits Coordinator at International Brotherhood of Painters and Allied Trades District Council NO.21 Welfare Fund, 2980 Southampton-Byberry Road, Philadelphia PA 19154 or by fax to (215) 677-3877. The Plan will attempt to honor your reasonable requests for confidential communications.

**Right to Inspect and Copy Your Health Information**. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to Benefits Coordinator at International Brotherhood of Painters and Allied Trades District Council NO.21 Welfare Fund, 2980 Southampton-Byberry Road, Philadelphia PA 19154 or by fax to (215) 677-3877. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

**Right to Amend Your Health Information**. If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made as long as the information is maintained by the Plan. A request for an amendment of records must be made in writing Benefits Coordinator at International Brotherhood of Painters and Allied Trades District Council NO.21 Welfare Fund, 2980 Southampton-Byberry Road, Philadelphia PA 19154 or by fax to (215) 677-3877. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied

## NOTICE OF HEALTH PLAN'S PRIVACY PRACTICES

if your health information records were not created by the Plan, if the health information you are requesting to amend is not part of the Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Plan determines the records containing your health information are accurate and complete.

**Right to an Accounting**. You have the right to request a list of certain disclosures of your health information that the Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing to Benefits Coordinator at International Brotherhood of Painters and Allied Trades District Council NO.21 Welfare Fund, 2980 Southampton-Byberry Road, Philadelphia PA 19154 or by fax to (215) 677-3877. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than **six (6)** years. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

**Right to a Paper Copy of this Notice**. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact Benefits Coordination at International Brotherhood of Painters and Allied Trades District Council NO. 21 Welfare Fund, at (215) 698-0978.

### DUTIES OF THE PLAN

The Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within sixty (60) days of the change. You have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing to Benefits Coordinator at International Brotherhood of Painters and Allied Trades District Council NO. 21 Welfare Fund, 2980 Southampton-Byberry Road, Philadelphia PA 19154 or by fax to (215) 677-3877. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

### CONTACT PERSON

The Plan has designated the Benefits Coordinator as its contact person for all issues regarding patient privacy and your privacy rights. You may contact the Benefits Coordinator by mail at 2980 Southampton-Byberry Road, Philadelphia PA 19154, by fax to (215) 677-3877 or by phone at (215) 698-0978.

# ADMINISTRATION AND CONTACT INFORMATION

| BENEFIT | TYPE OF ADMINISTRATION | TYPE OF FUNDING |
|---|---|---|
| **Hospital and Medical** | Capital Blue Cross<br>2500 Elmerton Avenue<br>Harrisburg, PA 17177<br>800.348.8172<br>www.capbluecross.com | The Fund pays premiums to Capital Blue Cross and the carriers provide benefits. |
| **Prescription Drug** | Express Scripts, Inc.<br>711 Ridgedale Avenue<br>E. Hanover, NJ 07936<br>800-467-2006<br>www.express-scripts.com | Express Scripts provides administrative services and the Fund pays for benefits. |
| **Dental** | Fidelio Dental Insurance Company<br>2826 Mount Carmel Avenue<br>Glenside, PA 19038<br>215-885-2443<br>1-800-262-4949<br>www.Fideliodental.com | Fidelio provides administrative services to the Fund, and the Fund pays for benefits. |
| **Vision Services** | NVA<br>1200 Route 46 West<br>Clifton, NJ 07013<br>800-672-7723<br>www.e-nva.com | NVA provides administrative services to the Fund, and the Fund pays for benefits. |
| **Weekly Disability Benefit** | District Council No. 21 Welfare Fund<br>2980 Southampton-Byberry Road<br>Philadelphia, PA 19154<br>215-934-5130 | The Fund administers and provides benefits. |
| **Life Insurance** | Amalgamated Insurance Company<br>Administrative Office<br>333 West Chester Ave.<br>White Plains, NY 10604<br>914-367-5361 | The Fund pays premiums to Amalgamated, and Amalgamated provides benefits. |
| **Accidental Death and Dismemberment Benefits** | Amalgamated Insurance Company<br>Administrative Office<br>333 West Chester Ave.<br>White Plains, NY 10604<br>914-367-5361 | The Fund pays premiums to Amalgamated, and Amalgamated provides benefits. |