SUMMARY PLAN DESCRIPTION
FOR THE
WELFARE FUND
OF THE
INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL 15, 15A, 15C, 15D AFL – CIO

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The security of your family is an important concern to us. Without adequate protection, the cost of an illness or injury could become a serious financial burden.

Naturally, the hope is that serious illness or injury never comes your way. However, if it does, then as a participant of the International Union of Operating Engineers Local 15, 15A, 15C & 15D Welfare Fund Plan, you can be assured that you and your family have the protection you need through a wide range of coverage.

How to Use This Manual

This manual is your summary plan description. It is designed to help you understand how your plan works. It is important for you to read this manual to understand what you are entitled to, and to make the best use of your plan coverage. The official plan document and trust agreement describe the provisions of the plan in more detail. They are the final authority with respect to your eligibility to participate in the Plan and the benefits you receive under the plan.

In order to understand your benefits more easily, the rules, provisions and benefit descriptions have all been arranged in alphabetical order by topic. For instance, if you wanted to enroll your newborn child in the plan, you would reference the “Enrollment” section, if you wanted to learn more about your vision benefits, you would reference the “Vision Benefits” section, and so forth.

Should you have any other questions about the plan and how its coverage works, contact the Welfare Fund Office at:

The Welfare Fund of the
International Union of Operating Engineers
Local 15, 15A, 15C and 15D
265 West 14th Street, Suite 500
New York, NY 10011
(212) 255–7657

Your Welfare Fund

Three important features differentiate this Welfare Fund from other welfare funds, as well as other insurance programs under which you may have been covered in the past.

First, the Welfare Fund began as and remains an indemnity welfare plan designed to reduce the out-of-pocket expenses incurred whenever its participants need catastrophic medical care or day-to-day medical care. Simply put, the Welfare Fund is here to help protect you against losing too much money when medical maladies arise in your life. As with other insurance plans, the Fund was never designed to fully pay for every procedure or expense associated with you or your dependent’s medical or dental care.

Secondly, the Welfare Fund Plan is a self-insured plan. As such, all of its participants’ contributions are pooled together. The healthy working members’ contributions, along with any investment interest income, are used to pay the medical claims of the less fortunate non-healthy participants.

Thirdly, regardless of any medical network affiliation, the Welfare Fund of the International Union
of Operating Engineers, Local 15, 15A, 15C & 15D provides you and your family’s medical coverage pursuant to its policies and provisions. The Welfare Fund does not contract with any other insurance carrier to provide you and your family with medical benefits. Instead, the Fund directly provides medical benefits to the participants and assumes the responsibility for paying the participant’s medical claims according to the terms, conditions and provisions set forth throughout this manual.

The Board of Trustees determines the benefits provided in accordance with all Plan provisions. As such, the Trustees retain the right by written amendment to this Summary Plan Description (SPD), to change, add, or delete benefits, eligibility rules, or any other provisions relating to the operation of the Fund.

The Trustees also retain the exclusive right to interpret coverage and benefit provisions of the Fund.

Minding What Matters...

As you will soon discover, the plan design of the Welfare Fund provides its participants with a tremendous amount of freedom to manage their healthcare issues in a manner that is appropriate to themselves and their family.

However, with any freedom, there comes responsibility. The existing and future financial strength of this fund is predicated upon participants responsibly becoming educated to the policies, and procedures contained within this book, as well as being responsible for their daily practice of superior healthy habits and behaviors.

The solvency of this plan is affected by several factors, the most important not limited to:

- Unhealthy and/or unlearned health habits and behaviors of its participants;
- Fraudulent claims;
- Billing inaccuracies;
- Lack of Plan knowledge;
- A decrease in contributions;
- Timely submission of medical claims and dental claims;
- A high rate of medical inflation (increase in the cost of medical goods and services);
- A decrease in investment income;
- An increase in the number of disabled participants;
- An increase in the number of younger retirees; and
- An increase in the average life span of the participating retiree population.

The first six items listed above are the biggest factors affecting the current financial strength of the Fund today. However, you have the most command over these factors. By following the steps listed below, you will help ensure the financial strength as well as the quality of your Welfare Fund benefits.

1. Eat healthy, exercise and get an annual physical. Failure to do these things often leads to
unnecessary complications, higher costs and premature death. Don’t wait until it is too late
to make your health a priority. Develop and maintain healthy habits, and have regular medical
and dental checkups.

2. Read this entire manual. Understanding your benefits and how they work will keep your out-
of-pocket costs to a minimum, and help reduce the costs to the Fund. If you do not
understand a particular benefit, do not hesitate to contact the Welfare Fund with any questions
you may have.

3. Always file claims associated with a work-related injury or illness with your employer’s
workers’ compensation insurance company.

4. Make sure you ask for your medical and dental bill at the time of service. This is the best time
to recognize billing inaccuracies. If the claim doesn’t look correct, ask your doctor to explain
the items on the claim and compare them to the services that were rendered to you or your
dependent.

5. Keep track of your medical claims. If you do not receive an Explanation of Benefits (EOB) from
the Welfare Fund within 4 to 8 weeks from the date of service, you should make a copy of the
bill you received at the time of service and send that copy to the address listed on your
insurance card for adjudication. Claims that are not received or filed in a timely manner will
become your responsibility to pay in full. For more information on what information is needed
on a claim please refer to the section of this book titled “Claims Filing”

6. Review the Explanation of Benefits (EOB) that you receive from the Fund. If it doesn’t seem
correct, contact the Fund Office immediately.

7. Make sure to collect all of your benefits stamps when they are due. If you are owed any
benefits from your employer, contact your business agent immediately.

8. Make sure to furnish the plan in writing with any information that may affect you and any of
your dependents eligibility. Remember, failure to supply change of addresses; name changes;
additions of dependents; marriage status; other insurance information; Medicare and Medicaid
status; Family Medical leave status; or Social Security disability benefits may result in you or
your dependents inability to claim benefits from this Fund or the termination of your benefits.

A Brief Overview of How Your Welfare Benefits Work

Benefits are offered through the Fund instead of cash. There are several good reasons for having
benefits sponsored by the Fund:

1. Because the Fund provides coverage for thousands of people, it can obtain better benefits at
lower costs than you could purchase individually.

2. A Fund-sponsored plan generally can offer protection to everyone. This means even those
people who might be considered uninsurable can get coverage.

3. Money the Fund spends on benefits is a form of tax-free income to you. If your Employers
paid you the same amount of money the Fund spends on your benefits, that money would be
taxed, leaving less to spend on benefits themselves.
The deductible. You are required to pay an annual deductible. Once your medical bills exceed the deductible limit, the Welfare Fund will begin to make payments according to the provisions and benefits set forth within this manual.

Medical providers. As a participant of the Plan, you are free to seek medical care from the provider of your choice. You have the option to utilize a participating provider or a non-participating provider at any time you need services. However, with this freedom comes responsibility. It is your responsibility to know the network affiliation of all medical practitioners being utilized by you and your family, as well as the provisions of the benefits that you seek.

In-network or participating providers. The Trustees have contracted with a medical provider network in order to help reduce any out-of-pocket costs that you may incur when seeking medical attention. If you choose to access the services of one of these participating providers, the Fund will pay 100% of the negotiated fee for covered services that exceed your deductible.

Keep in mind that the Welfare Fund maintains lifetime limits, annual caps, and restrictions on certain medical benefits. These limits, caps and restrictions will be adhered to regardless of whether you use an in-network provider. As such, you may be responsible for any outstanding balance for services provided.

Out-of-network medical providers. For active participants who choose to utilize an out-of-network physician, after the deductible has been met, the Welfare Fund will do one of the following:

- Pay 80% of the Fund’s usual, customary and reasonable fee schedule for that covered service or procedure; or
- Pay up to, but not exceed, the particular limit of that specific benefit or service as set forth within this document.

For retired participants who do not have Medicare benefits and who elect to utilize an out-of-network physician, after the deductible has been met, the Welfare Fund will do one of the following:

- Pay 75% of the Fund’s usual, customary and reasonable fee schedule for that covered service or procedure; or
- Pay up to, but not exceed, the particular limit of that specific benefit or service as set forth within this document.

Below are some of the more significant benefits that the Welfare Fund covers for eligible participants:

- Annual Physical
- Accidental dismemberment
- Acupuncture
- Anesthesia
- Cardiac therapy
- Chemotherapy
- Chiropractor
- Death
- Dental
- Diagnostic Testing
- Disability
- Durable medical equipment
- Emergency treatment
- Gastric Bypass / Bariatric Surgery
- Hearing aid
- Home care
- Hospital
- Hospice
- Infertility treatment
- Laboratory/Diagnostic Testing
- Maternity
- Mental health
- Newborn care
- Occupational Therapy
- Optical
- Orthodontics
- Orthotics
- Prescription Drugs
- Pre-surgical testing
- Physical therapy
- Psychological
- Podiatrist
- Preventive care
- Radiology
- Radiation therapy
- Respiratory therapy
- Rolfing Therapy
- Speech Therapy
- Substance abuse
- Surgery
- X-ray
To further assist you in navigating this summary plan description, we have assigned the following icons to most benefit descriptions in order to facilitate quicker comprehension:

- $ Deductible applies
- Limited Number of Days or Visits
- Limited /Capped Benefit by $$ Dollar Amount
- Applies towards the Major Medical Lifetime Cap
- Benefit requires a Prior Approval and a Letter of Medical Necessity

DEFINITIONS:

ACUTE: The sudden onset of disease or injury, or a sudden change in the participant’s condition that would require prompt medical attention.

ADJUDICATION: The administrative procedure used to process a claim for service according to the covered benefit.

ALLOWABLE CHARGE: The maximum charge payable for any given procedure as determined according to the methodology selected by the Board of Trustees at their sole discretion. (Please refer to the section of the book titled Usual, Customary and Reasonable Charges as well as to the definition under the same title within this section)

AMBULATORY SURGERY: Surgery performed as an outpatient basis in an accredited hospital or approved surgical center.

ANNUAL MAXIMUMS: Certain benefits provided under the Plan are also subject to Annual Maximums for each eligible participant during each calendar year. Once the Plan has paid the Annual Maximum for any of those services or supplies it will not pay any further for that year.

ASBESTOS-RELATED DISEASES: All those states of ill health that arise out of, or are associated with, past exposure to asbestos. These include: Asbestosis, Lung cancer, Mesothelioma, and other cancers.

ASSIGNMENT OF BENEFITS: When a covered person authorizes his or her health benefits plan to directly pay a health care provider for covered services.

If you want the Fund to pay your medical provider directly, sign the "Assignment of Benefits" portion of the claim form. Then the Fund makes direct payment to the provider and sends you an explanation of benefits (EOB) so you know what was paid.

BENEFICIARY: A person who is designated by you to receive benefits under this Plan.
CALENDAR YEAR: Calendar Year: Calendar year is January 1 through December 31.

CHEMOTHERAPY: Treatment of disease by chemical compounds.

CLEAN CLAIM: A clean claim is defined as a complete claim, or an itemized bill that does not require any additional information to process it.

C.O.B.R.A: C.O.B.R.A. is the acronym for the federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. This law allows you and your eligible dependents to continue your health care coverage with the Fund at your own expense provided your coverage was terminated for one of the specific reasons stated below.

- Termination of your employment for any reason, except gross misconduct.
- Loss of you eligibility due to reduced work hours.
- Your death.
- Your divorce from your spouse.
- Your dependent child ceasing to be a dependent.
- Your dependent’s loss of eligibility because you become entitled to Medicare benefits.

COINSURANCE: The amount of charges for covered service that you are required to pay to a non-participating provider, after your deductible has been met.

COLLECTIVE BARGAINING AGREEMENT: The contract(s), as amended, between the Union and any Employer or any Association covering wages, hours and conditions of employment requiring contributions to this Plan.

COPAYMENT: The predetermined amount of money an individual is required to pay directly to a network Provider at the time covered services are rendered. (At the time of print for this handbook, the Fund does NOT require a co-payment to be made to a network provider).

COSMETIC SURGERY: For purposes of procedures covered under this plan, cosmetic surgery means any surgical procedure performed primarily to improve physical appearance or restore or change bodily form without materially correcting a bodily malfunction.

COVERED EXPENSE, OR COVERED SERVICES: Covered expense or covered service includes expenses covered under the Plan for treatment, care, services, or supplies, but only to the extent that:

- They are Medically Necessary;
- Coverage is not excluded under the Plan; and
- No Plan maximums for those expenses have been reached.

COVERED DEPENDENTS: Your spouse, unmarried dependent and newborn children, or parents as described in the “Eligibility” section of this book.

DEDUCTIBLE: The sum of out of pocket expenses that each participant must pay each calendar year before the Plan begins to pay benefits.

For example, if the plan has a $100.00 deductible, the deductible is met once that person has paid the first $100 of the covered medical expenses for that year. After that, the plan begins to pay
toward the cost of the covered health care services.

**DIAGNOSIS:** Identifying a disease by its signs, symptoms, course and laboratory findings.

**DURABLE MEDICAL EQUIPMENT:** Durable Medical equipment is equipment that:

- Is primarily and customarily used to serve a medical purpose;
- Can withstand repeated use;
- Generally is not useful to a person in the absence of an illness or injury; and
- Is appropriate for use in the home.

Equipment presumed to be medical includes such items as Hospital beds, wheelchairs, hemodialysis equipment, intermittent positive pressure breathing machines, walkers, and traction equipment.

Equipment presumed to be non-medical includes such items as air conditioners, humidifiers, dehumidifiers, and electric air cleaners. In addition, medical equipment does not include non-medical equipment:

- That basically serves comfort or convenience functions;
- That is primarily for the convenience of a person caring for the patient, such as stairway elevators, posture chairs, and cushion lift chairs; and
- For physical fitness, such as exercycle, precautionary-type equipment, preset portable oxygen units, training equipment, and speech teaching machines.

You are responsible for expenses associated with the maintenance or repair of Durable Medical Equipment.

Durable Medical Equipment may, at the Fund’s sole discretion, be replaced if the:

- Equipment is no longer useful and has exceeded its reasonable lifetime under normal use; or
- Patient’s condition has significantly changed so as to make the original equipment inappropriate in the judgment of the Physician

Durable Medical Equipment is not replaced as a result of loss due to accident, theft, or abuse.

Durable Medical Equipment that has been purchased by the Fund cannot be given, donated or discarded without the written consent or permission of the Fund. Participants who do not get the permission of the Fund will be responsible to remunerate to the Fund the full purchase price of said equipment.

**EFFECTIVE DATE:** The date on which coverage under a health benefits plan begins.

**EMPLOYER:** Any Employer who contributes, or is required to contribute, to the Fund pursuant to the terms of a Collective Bargaining Agreement or other written agreement.

**EXECUTE:** To sign and complete in its entirety the Funds enrollment, claim, or verification forms or any other document issued or requested by the Welfare Fund.

**EXPLANATION OF BENEFITS (EOB):** A statement provided by the Welfare Fund that explains the benefits provided, the allowable reimbursement amounts, any deductibles, coinsurance or other adjustments taken and the net amount paid.
A participant typically receives an explanation of benefits with a claim reimbursement check or as confirmation that a claim has been paid directly to the provider.

**FUND:** The Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D.

**FULL TIME STUDENT:** A full time student is defined as a person who is taking a minimum of 12 credits at an accredited school, or a person to whom the accredited school bursars or administrative office has attested as a full time student.

Proof of full time student status must be submitted in writing to the Fund Office prior to the termination of the grace period to ensure continuity of coverage.

**GLOBAL FEE:** The term used to define an all-inclusive payment for the professional and technical services for a medical procedure.

**GOVERNMENT B READER:** A physician who has had specialized training in the interpretation of chest X rays for dusty lung disease and who passed a test given by the American College of Physicians/NIOSH

**GRACE PERIOD:** The amount of time in which a participant can be late on submission of a payment, verification form or other document without being considered in default.

**HOME HEALTH CARE AGENCY:** An organization currently certified or licensed by the State, which can provided home health services.

**HOSPITAL:** Hospital is an establishment that:

- Holds a license as a hospital (if licensing is required in the state)
- Operates primarily for the reception, care, and treatment of sick or injured persons as inpatients;
- Provides 24-hour-a-day nursing service by registered graduate nurses;
- Has a staff of one or more licensed Physicians available at all times; and
- Provides organized facilities for diagnostic and major surgical facilities.

In no event does the term Hospital mean an institution or that part of an institution that principally is used as a:
- Clinic;
- Convalescent home;
- Rest home;
- Nursing home; or
- Home for the aged.

For the purpose of mental or nervous disorders, or rehabilitation for substance abuse, Hospital means a place, that:

- Has accommodations for resident bed patients;
- Has facilities for the treatment of mental or nervous disorders or substance abuse;
- Has a resident psychiatrist on duty at all times; and
- Charges the patient for the expense of confinement as a regular practice.

A legally operated institution rendering inpatient and outpatient services for the medical care of the sick or injured. Either the Joint Commission on Accreditation of Health Care Facilities or the Bureau of Hospitals of the American Osteopathic Association must accredit it as a Hospital. A Hospital may be a general, acute care, or a specialty institution, provided that it is appropriately accredited as such, and currently licensed by the proper state authorities.

**LETTERS OF MEDICAL NECESSITY:** A physician, psychiatrist, or psychologist must be the issuer of a letter of medical necessity. The letter must contain the diagnosis codes, treatment goals, and suggested treatments.

**LIEN / SUBROGATION REIMBURSEMENT AGREEMENT:** An agreement that gives the Fund the right to recover payment for any amount it has paid or will pay arising out of, or relating to, any and all of the rights, claims, causes of action, and interest which you (your spouse or covered children) may have against any person, firm, corporation, insurance company, payer, uninsured motorist fund, no-fault insurance carrier, or other entity in regard to such injuries, expenses or losses.

**LIFETIME BENEFIT / MAXIMUMS:** Certain benefits provided under the Plan are also subject to Lifetime maximums for each eligible participant. Benefits paid by the Fund during an individual’s lifetime participation in the Plan may not exceed the lifetime Maximum listed.

While covered under the Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D, lifetime shall be used in to reference benefit maximums and limitations. Under no circumstances does Lifetime mean “during the lifetime of the covered Participant.”

**MAMMOGRAPHY:** A low dose X-Ray technique for studying the structure of a breast tissue in order to locate any abnormality at the earliest possible stage; permits detection of a breast cancer before the lump can be felt.

**MEDICAL EMERGENCY:** A medical or behavioral condition the onset of which is sudden, that manifests itself by symptoms of severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Emergency first aid for an accidental injury rendered within 72 hours following such injury, or
- Emergency care within 12 hours of the onset of sudden or serious illness, or
- Use of the hospital’s facilities for a surgical operation.
- Placing the health of the afflicted member with such a condition in serious jeopardy, or in the case of a behavioral condition placing the health of such member or others in serious jeopardy;
- Serious impairment to the members bodily functions;
- Serious dysfunction of any bodily organ or part of such member or:
- Serious disfigurement of such Member.

**MEDICALLY NECESSARY:** Those services and supplies provided by a Hospital, Physician or other licensed provider of health care services to identify or treat an illness or injury which has been
diagnosed or is reasonably suspected, and which are:

- Appropriate and consistent with a medical diagnosis provided by a legally qualified Physician or surgeon operating within the scope of his or her license;
- In accordance with the acceptable standards of community practice;
- Could not have been omitted without adversely affecting either you or your eligible dependent’s condition or quality of medical care.
- Required for reasons other than your convenience, or that of the Physician or other licensed provider, and
- The most appropriate supply or level of service, which can be provided for your safety.

When the term “Medically Necessary” is used to describe inpatient hospital care, it means that your medical symptoms or condition require that the service or supplies cannot be provided safely on an outpatient basis. The fact that a service or supply is prescribed by a Physician or another licensed provider does not necessarily mean that such service or supply is “Medically Necessary.” Moreover, the fact that a service or supply is Medically Necessary does not automatically mean that such service or supply is covered by this Plan.

MEDICARE: Title XVIII of the Social Security Act, as amended, that provides payment for medical and health services to the population aged 65 and over regardless of income, as well as certain disabled persons and persons with ESRD.

MEDICARE PART A: Hospital insurance provided by Medicare that can help pay for inpatient hospital care, medically necessary inpatient care in a skilled nursing facility, home health care, hospice care and end-stage renal disease treatment.

MEDICARE PART B: Medicare-administered medical insurance that helps pay for certain medically necessary practitioner services, outpatient hospital services and supplies not covered by Part A hospital insurance of Medicare coverage. Doctors services are covered under Part B even if they’re provided to a member in an inpatient setting. Part B can also pay for some home health services when the beneficiary doesn’t qualify for Part A.

MEDICARE PART D: Medicare Part D Prescription Drug Coverage is the name given to the Medicare program that provides prescription insurance coverage to everyone who is eligible for Medicare benefits. Private companies provide this coverage. You choose the drug plan and pay a monthly premium.

MEDIGAP: A term used to describe health benefit coverage that supplements Medicare Coverage or that is used in lieu of Medicare Coverage.

MENTAL or NERVOUS DISORDER: A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder, if the cause of such condition is not organic or the result of externally induced chemical agents.

MORBID OBESITY: For purposes for procedures covered under this plan, morbid obesity is defined as an adult who has been more than 100 pounds over normal weight for at least five years.

NETWORK PROVIDER: Is any of the following who alone, or as a part of a the following group, enter into a contract with the Trustees directly or through their agents, and agree to be compensated for services and supplies as covered under this Plan according to the terms of the contract while such contract is in effect.
• Physician, registered nurse, physical therapist, or other duly licensed health care provider or certified institution;
• Hospital;
• Alcohol and controlled substance abuse treatment facility;
• Hospice;
• Laboratory;
• Outpatient surgical facility;
• Pharmacy;
• Business establishment selling or renting Durable Medical Equipment; or
• Any other source for services or supplies covered under the Plan.

NO-FAULT MOTOR VEHICLE INSURANCE PLAN: No-Fault Motor Vehicle Plan is a motor vehicle plan that is required by law and provides payments for medical expenses (including transplants), in whole or in part, without regard to fault. Anyone subject to this kind of law who does not comply will be deemed to have received the benefits required by the law.

OTHER HEALTH PLANS: Other Health Plans / Other Group Plan / Other Insurance Plan is any plan, policy, contract, or other arrangement that provides benefits or services to you or your eligible dependents for, or by reason of, medical, dental, vision, or hearing care, treatment or healing under:
• Benefit programs provided by an employer
• Group insurance;
• Group practice, individual practice, or other prepayment coverage;
• Health Maintenance Organizations;
• Plan Provider Organizations;
• Labor-management Trusteed, union welfare, employer organization, or employee benefit organization plans; or
• Government programs or coverage required or provided by any statute.

OUT OF POCKET: Co-insurance, deductibles, co-payments or fees paid by participants for health services or prescriptions.

PAIN MANAGEMENT / PALLIATIVE TREATMENT: Providing relief from symptoms of a disease but not directly curing the disease; alleviating pain.

PARTICIPATING PROVIDER OR PREFERRED PROVIDER: Is any of the following group who alone, or as a part of a group, enter into a contract with the Trustees directly or through their agents, and agree to be compensated for services and supplies as covered under this Plan according to the terms of the contract while such contract is in effect.
• Physician, registered nurse, physical therapist, or other licensed health care provider;
• Hospital;
• Alcohol and controlled substance abuse treatment facility;
• Hospice;
• Laboratory;
• Outpatient surgical facility;
• Pharmacy;
• Business establishment selling or renting Durable Medical Equipment; or
• Any other source for services or supplies covered under the Plan.

**PHYSICIAN:** A person who is licensed to practice medicine in his jurisdiction and practicing within the scope of his license. In determining what services are covered by this Plan, Physician includes a Medical Doctor or a Doctor of Osteopathic Medicine. In certain circumstances other professionals, such as podiatrists, chiropractors, Dentists, optometrists and psychologists, who fulfill these requirements can be considered Physicians.

**PHYSICIAN ASSISTANT:** Physician assistants (PA) provide healthcare services under the supervision of a physician.

Services provided by physician assistants are not covered under this Plan.

**PLAN:** The Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D, plan document as adopted and amended by the Board of Trustees, which sets forth the provisions governing the eligibility for and benefits provided by the Fund.

**PLAN FUNDING:** The Welfare Fund has been created to provide health care coverage to eligible persons. A portion of the negotiated wage package determined by collective bargaining between the I.U.O.E., Local 15, 15A, 15B, 15C and 15D and your employer has been designated for the Fund to provide this coverage.

**PRESCRIPTIONS:** A written order issued by a legally qualified Physician or surgeon to a legally qualified and duly licensed pharmacist for any drug or medicine that has been approved for general use by the FDA and that is given by such Physician or surgeon for the Eligible Person.

This does not include drugs or other forms of medication that may be legally obtained without a Prescription, even though such drugs or medication may be prescribed.

**PRETREATMENT ESTIMATE:** Pretreatment Estimate is a predetermination of the benefits payable by the Plan. Predetermination of benefits helps you avoid surprises by letting you and your provider know in advance what services are covered and what payment will be made by the Fund.

**PRIOR APPROVAL:** A requirement to submit a letter of medical necessity that includes a diagnosis and a treatment plan prior to receiving services or supplies. This review process evaluates the medical necessity and appropriateness of a proposed service or care. This includes, but is not limited to, some dental claims, home care benefits or outpatient services or treatment, admissions for mental health or substance abuse, admissions for physical rehabilitation, certain prescription drugs, certain surgical procedures.

**QUALIFYING EVENT:** Any of the events resulting in loss of coverage and which would qualify a Covered Employee or Dependent for C.O.B.R.A., continuation coverage.

**RETIREE:** A person who is awarded and receiving a pension from the Central Pension Plan of the International Union of Operating Engineers, AND who meets the conditions for eligibility as set forth in the Plan.
SILICOSIS: A disease of the lungs caused by the inhalation of finely divided free silica dust. Where silica dust accumulates, a fibrous tissue develops and grows around the particle. It is not as elastic as normal lung tissue, and does not permit the ready passage of oxygen and carbon dioxide.

SUBROGATION: Subrogation means the Welfare Funds right to recover any payments made because of an injury to you or your dependents caused by a third party's wrongful act or negligence, and which you or your dependents later recover from the third party or the third party's insurer.

SURGERY CENTERS OR SURGERY FACILITY: A legally operated institution rendering outpatient services for the medical care of the sick or injured. Either the Joint Commission on Accreditation of Health Care Facilities or the Bureau of Hospitals of the American Osteopathic Association must accredit it as a Hospital affiliated surgery center or facility. A surgery center or surgery facility may be a general, acute care, or a specialty institution, provided that it is appropriately accredited as such, currently licensed by the proper state authorities, and affiliated with a participating hospital.

For the purpose of this Plan, the term surgery center or surgery facility does not include an institution, center or facility or part of one, which is not affiliated with participating hospital and does not meet the criteria listed in the aforementioned paragraph.

THIRD PARTY: A third party means another person or organization.

TRUST AGREEMENT: The Agreement and Declaration of Trust entered into between the Union and Contributing Employers establishing the Fund.

TRUSTEES: The Fund Trustees acting pursuant to the Agreement and Declaration of Trust establishing the Fund, and any successor Trustees, duly designated in the manner set forth in the Agreement and Declaration of Trust.

USUAL, CUSTOMARY AND REASONABLE FEE SCHEDULE: The usual, customary and reasonable fee schedule is a compilation of the amounts providers frequently accept for the same service or procedure in your geographical area. What the Fund covers/reimburses is based on this fee schedule. The Fund is the sole determiner of the usual, customary and reasonable fee schedule.

If a member happens to be using a particularly expensive non-participating or non-network provider that is charging more than the usual, customary and reasonable fees, then the member will be responsible for the deductible amount PLUS any charges in excess of what the Welfare Fund reimbursed.

WORK DISABILITY: A health or physical condition, arising out of the workplace, which hinders a person in work activity. Such a disability may be partial or complete.

WORKER’S COMPENSATION: Federal and State programs designed to provide cash benefits and medical care to workers injured or diseased in connection with their work, and payments to the survivors of those who sustain fatal injuries or diseases.

YOU: As used in this booklet, the term “You” refers to the member, as an individual, or to the member and her/his family, as an entity, depending on the context in which it is used.
Benefits and Provisions for Active Working Members and their Eligible Dependents

The medical benefits described in this section of the summary plan description are available to all eligible active participants and their eligible dependents unless otherwise specified.

The section and paragraph headings contained herein are for the purposes of convenience only and are not intended to define or limit the contents of said sections or paragraphs. Words and definitions in the singular shall be read and construed as though in the plural where the context so requires, and vice versa, and words in the masculine, neuter or feminine gender shall be read and construed as though in either of the other genders where the context so requires.

Once more, we strongly suggest that you read through this entire manual carefully in order to limit any financial liability you may incur. Additionally, we would like to reiterate that future health benefits are not guaranteed and are subject to change.

Things to remember...

In general, most benefits are subject to a calendar-year deductible. If the calendar year deductible has not been met, a portion or the entire allowable benefit amount will be applied towards the deductible before the Fund will make payment.

The Welfare Fund maintains lifetime limits, annual caps, and restrictions on certain medical benefits. These limits, caps and restrictions will be adhered to regardless of the utilization of an in-network provider.

Some services and treatments require prior-approval by the Fund. The Fund will not make payments for services that are rendered prior to the Fund’s written approval for the particular treatment or service. In order to receive written approval (and hence payment for these benefits) the member is required to mail or fax to the Fund prior to that treatment or service the attending physician’s or surgeon’s written description of the present illness together with a complete medical report.

The Fund will not make any payment for services after the participant’s lifetime medical maximum allowance has been exhausted.

Services performed by participating providers will be paid according to the Fund’s negotiated rates for said service.

Services performed by non-participating providers will be paid at 80% of the Fund’s usual, customary and reasonable fee schedule for said service.
Accidental Dismemberment

Initial Eligibility: All new members and reinstated members must satisfy the following two criteria before they can be eligible for this benefit:

1. You must satisfy a waiting period of six months in which you must be performing unit work within the jurisdiction of Local 15, 15A, 15C and 15D.

2. You must have fulfilled the following Initial Hourly Requirement as stated below.

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<thead>
<tr>
<th>Agreement</th>
<th>Initial Hourly Requirement</th>
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<tr>
<td>Local 15-15A</td>
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<td>Local 15C</td>
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<td>Local 15C – Sims Hugo Neu</td>
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<td>Local 15C – Small Tool</td>
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<td>Local 15D</td>
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<td>Local 15D – Consultant Surveyor</td>
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<td>Local 15D – Nelson &amp; Pope</td>
<td>529</td>
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Ongoing Eligibility: Upon satisfying the mandated initial eligibility requirements, the following criteria must be met each benefit period in order to continue eligibility for this benefit.

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<tr>
<th>Agreement</th>
<th>Ongoing Eligibility Requirements</th>
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<tr>
<td>Local 15-15A</td>
<td>112.5 for one benefit period</td>
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<td>225 for two benefit periods</td>
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<td>338 for three benefit periods</td>
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<td>Local 15C</td>
<td>112.5 for one benefit period</td>
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<td>225 for two benefit periods</td>
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<td>338 for three benefit periods</td>
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<tr>
<td>Local 15C – Sims/ Hugo Neu</td>
<td>138 for one benefit period</td>
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<td>275 for two benefit periods</td>
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<td>413 for three benefit periods</td>
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<td>Local 15C – Small Tool</td>
<td>118 for one benefit period</td>
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<td>236 for two benefit periods</td>
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<td>354 for three benefit periods</td>
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<td>Local 15D</td>
<td>112.5 for one benefit period</td>
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<td>225 for two benefit periods</td>
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<td>338 for three benefit periods</td>
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<td>Local 15D – Consultant Surveyor</td>
<td>142 for one benefit period</td>
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<td>284 for two benefit periods</td>
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<td>427 for three benefit periods</td>
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<tr>
<td>Local 15D – Nelson and Pope</td>
<td>159 for one benefit period</td>
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<td>317 for two benefit periods</td>
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<td>476 for three benefit periods</td>
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Acupuncture

The Fund will allow up to 16 visits per calendar year for services performed by a medical doctor, LAC (Licensed Acupuncturist), or DOM (Doctor of Osteopathic Medicine) only. Benefits are limited to one service per day. Benefits will be paid for medical diagnosis only.

Services performed by a participating provider will be subject to the deductible and will be paid according to the negotiated rate for the service.

Service by a non-participating provider will be subject to the deductible and will be paid at 80% of the Fund’s usual, customary and reasonable fee schedule for the service.

Ambulance & Ambulette

Ambulance services, including air ambulance or air transportation (flight for life) for life-threatening medical emergencies, are covered. Ambulance and Ambulette services for all other medical emergencies will be covered only when deemed medically necessary. When deemed medically necessary, the Fund will pay participating ambulance and ambulette services according to the negotiated rate for all intra-facility transfers. For non-participating services, the Fund will pay 80% of the Fund’s usual, customary and reasonable fee schedule for intra-facility transfers.

However, if the needed care is not available locally, the Fund will pay for intra-facility ambulance and ambulette transportation outside your local area to the closest facility that can provide the care. Payment for transportation to another facility located further away will be based on how much it would have cost for transportation to the closer facility.

Anesthesia

Benefits are payable in connection with a surgery when anesthesia is administered by a doctor other than the operating surgeon, his or her assistant or an employee of the hospital or certified nurse anesthesiologist.

Participating provider charges will be subject to the deductible, and payable at the negotiated rate.

Non-participating provider charges will be subject to the deductible and payment will be made at 80% of the Funds usual, customary and reasonable (UCR) fee schedule for the base unit and time unit. Use the following formula when negotiating with an non-participating anesthesiologist or whenever you are calculating your co-insurance:

\[ \text{Base Unit UCR} + \text{Time Unit UCR} \times 80\% \] = Non-participating reimbursement

To obtain the usual, reasonable and customary charge for the base unit and time unit, please call the Welfare Office at (212) 255-7657, or go online to benefitfunds.iuoe15.org.
NOTE: Most hospitals contract with independent physicians, surgeons and medical professionals. These individuals are independent contractors and not on the hospital’s payroll. Therefore, do not assume that all the medical providers assisting during your inpatient hospital stay, inpatient surgery or outpatient surgery participate in the network.

As always, you should refer to your provider directory as well as the provider’s Web site to find out whether or not the anesthesiologist, as well as every other medical professional being selected for your procedure, participates within the network.

Annual Health Maintenance Routine/Compliance Based Health Plan

Unhealthy behaviors are like gravity. Gravity doesn’t announce itself. It just is. However, if you violate the laws of gravity you have consequences. The same can be said with the laws of health.

Despite advances in medicine, many illnesses, accidents or diseases still result in disability and sometimes death. Fortunately, many of these maladies can be avoided completely or their severity reduced by maintaining healthy behaviors and by adhering to an annual health maintenance program.

Left unchecked, unhealthy behaviors could affect your Benefit Plan in one or more of the following ways:

1. Increased hourly premiums, and/or
2. Reductions in existing plan benefits, and/or
3. Modifications in coverage periods

Obviously, no one wants to see these actions taken. Unless, each of us incorporate a healthier lifestyle into our daily routine, the Trustees may be forced to integrate “measures of compliance” into the future benefit structure of the Plan.

These amendments may include, but are not limited to:

- Mandatory, annual individual health maintenance routines. These programs may be designed around age or gender-appropriate guidelines for well care and for condition management, to which each participant is obligated to adhere; and,
- Individual financial obligations or increased cost sharing based on the participants compliance efforts.

Each day brings new opportunities. What steps can be taken daily to ensure a healthier you?

1. Reflect upon how your current health is affecting the various areas of your life.
2. Consider how yours and your family’s unhealthy daily actions create unnecessary and unhealthy reactions; be it physical, mental and / or monetary.
3. Seek Guidance. It is available if you choose to make improvements. Today, it is easier than ever to get the information and assistance you require to make the modifications for a healthier tomorrow.
4. Don’t wait!

As a self-insured Benefit Fund, we are all responsible for its financial strength. By consistently making strides toward improving our daily health, and by becoming more informed to the consequences of our daily actions, we all have the potential to improve our physical, mental and monetary well being.
Annual Physicals

The Fund recommends that each eligible participant have a physical once every calendar year.

Participating provider charges will be subject to the deductible, and payable at the negotiated rate.

Non-participating provider charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule.

For the convenience of the membership, the Fund has contracted with the Professional Evaluation Medical Group (PEMG) to provide each participant with an annual physical and hearing test. If a participant utilizes the services of PEMG for the annual physical and hearing test, there will be no charge toward the participant’s annual deductible and lifetime major medical with no out of pocket expense for the services rendered.

Please note that although the Professional Evaluation Medical Group (PEMG) has successfully handled numerous physical examinations for Local 15 members and participants, you are not required to utilize their services. You may elect to take your annual physical with any physician you wish. As such, the Fund will make payment for those services according to the network affiliation, or lack thereof, outlined prior.

Appeals

Please refer to the section of this book entitled “Claims Appeal Procedure.”

Assistant Surgeons

Benefits are available for one assistant surgeon per inpatient operative session when, and only when, the hospital does not employ a house staff of surgeons/surgical residents or when a surgeon/surgical resident is unavailable to assist the surgeon, or when necessitated by law. The complexity of the surgical procedure will determine if the services of an assistant surgeon are appropriate and covered.

Participating provider charges will be subject to the deductible, and payable at the negotiated rate.

Non-participating provider charges will be subject to the deductible and payment will be calculated using the following formula:

\[ \frac{1}{4} \text{ of the Fund’s usual, customary and reasonable fee for the surgeon multiplied by 80%}. \]

Bariatric Benefits

Please refer to the section of this book entitled Gastric Bypass.
Beneficiary

The Plan will pay the Death Benefit to the beneficiary you designate and who is on record with the Fund Office at the time of death. You may change your beneficiary at anytime. To change beneficiaries, contact member services at 212-255-7657, or go to benefitfunds.iuoe15.org and print out a form. The Fund Office will provide you the form needed to make the change. You may also name more than one beneficiary. If your marital status or the number of your dependents changes, you may want to review your beneficiary designation. Remember, it is your responsibility to keep your beneficiary designation current.

If any designated beneficiary dies before you, that beneficiary’s right to the Death Benefit terminates. If there is no beneficiary designation on file, your Death Benefit will be paid to either:

1. To your surviving spouse; or

2. To the individual’s estate.

For more information please reference the section of the summary plan description titled “Death Benefit”.

Breast Sonogram Testing

The Fund will allow up to two breast sonograms per calendar year for eligible participants.

If more than two sonograms are necessary, the Fund office must receive a letter of medical necessity prior to the service being rendered. If the Fund does not receive the letter of medical necessity prior to the service date, the Fund will not make any payment toward those sonograms.

Sonograms performed in a participating hospital or facility will be subject to the deductible and will be paid at 100% of the negotiated rate.

Sonograms performed in a non-participating facility or hospital will be subject to the deductible and will be paid at 80% of the Fund’s usual, customary and reasonable fee schedule.

Sonograms performed in a non-participating private physician’s office will be subject to the deductible and will be paid at 80% of the Fund’s usual, customary and reasonable fee schedule.

The physician charge for the reading of the screening will be subject to the deductible and will be paid at 100% of either the negotiated rate for participating providers or 80% of the Funds usual, customary and reasonable fee schedule for non-participating providers.
Cardiac Rehabilitation

Prior approval is necessary before the Fund can make payment for this benefit.

Participating provider charges will be subject to the deductible, and payable at 100% of the negotiated rate up to the maximum allowable visits of 36 per year and per illness with a lifetime cap of 120 visits.

Non-participating provider charges will be subject to the deductible and will be payable up to $85 dollars per day inclusive of all physician fees and facility charges. The maximum allowable visits permitted per year and per illness are 36 with a lifetime cap of 120 visits.

Regardless of network affiliation, services not supervised by a physician will not be paid.

Catastrophic Case Management

If you or a member of your family is seriously ill or injured, case management medical personnel are available to work with you, your doctor and your family to develop an effective long-term treatment plan.

In most instances, case management is a voluntary feature of your medical benefits, and no penalty applies if you choose not to use it. However, certain illnesses and conditions necessitate the utilization of case management. In those instances, the Fund reserves the right to direct medical professionals to monitor your treatment.

If your condition qualifies for case management, a medical professional will notify you and your doctor about the availability of the program. If elected, or assigned case management will monitor your progress, coordinate delivery of services, supplies and equipment, and serve as an ongoing source of information about available treatment alternatives.

The case management department is staffed by medical professionals who will answer your health care questions quickly and confidentially. To take advantage of case management, call member services at 212-255-7657 and they will direct you to a case management professional specific to your condition.

Chemotherapy

Chemotherapy in physicians office or facility other than a hospital

Participating provider charges and facility charges will be subject to the deductible, and payable at the negotiated rate. All charges will be applied to the participant’s lifetime major medical allowance.

Non-participating provider charges and facility charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule when chemotherapy infusion is rendered in a physician’s office or a facility other than a hospital. All charges will be applied to the participant’s lifetime major medical allowance.
Chemotherapy in Hospital

Benefits will be paid at 100% when chemotherapy infusion is provided in a hospital. Payments for this benefit will not accumulate toward a participant’s lifetime major medical allowance. Annual deductible does not apply.

The Fund will not make any payment toward medical services, treatments, drugs or supplies that are considered educational, investigational, or experimental.

Chiropractic Benefits

The Fund allows up to 24 visits per calendar year and up to 4 Chiropractic X-rays per calendar year.

Participating provider charges will be subject to the deductible, and payable at the negotiated rate for either one manipulation or one office visit when performed on the same day.

Non-participating provider charges will be subject to the deductible and payable at a maximum of $50.00 for either one manipulation or one office visit when performed on the same day. X-rays will be paid at 80% of the Fund’s usual, customary and reasonable fee schedule.

**Note:** Modalities, i.e., physical therapy, provided by a chiropractor are not covered by the Plan.

Circumcision

Participating provider charges will be subject to the deductible, and payable at 100% of the negotiated rate.

Non-participating provider charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule.

Claims Appeal Procedure

To assure prompt payment of a claim for benefits, please keep a detailed record of all covered expenses incurred. You should keep in mind that it may be someone else’s responsibility to file a claim for benefits, for example, in the event of your death. Therefore, someone in addition to yourself should read this manual and become familiar with the Plan’s benefits and claims procedures.

**What is a claim?** A “claim” is a request from you or your authorized representative for payment of your Plan benefits made in accordance with the Plan’s reasonable procedures. Please refer to the “Claims Filing Procedure” section of this manual for details on how to file a claim.

If you file a claim for a specific benefit and your claim is denied because you are not eligible for the benefit under the Plan, the coverage determination would be considered a claim.

Casual inquiries about benefits or the circumstances under which benefits might be paid would not be considered claims.
A request for a determination of whether an individual is eligible for benefits under the Plan would not be considered a claim.

Your right to an authorized representative. If you wish, you can appoint an authorized representative to act on your behalf for the purposes of filing a claim, calling to get status on a claim and seeking an appeal of a denied claim. You can also simply choose to represent yourself. In order to use an authorized representative (this person may be an attorney, but need not be), however, you must notify the Fund Office in advance of the designation in writing. HIPAA Forms are available through the Fund Office. The Plan may request additional information to verify that this person is authorized to act on your behalf.

Determination of a benefit claim. The period of time for the Plan to make a benefit determination begins at the time the claim is filed in accordance with the Plan's procedures, without regard to whether all the necessary information accompanies the filing. The determination of benefit claims will vary depending on the type of claim.

Please read each of the following sections carefully to determine which procedure is applicable to your request for benefits.

Medical, pharmacy, dental and vision benefits claims. The Plan differentiates between four types of claims, divided according to their urgency. In general, dental, vision and pharmacy claims will be treated as post-service claims.

Pre-service claims. A pre-service claim is a claim for a benefit for which the Plan requires prior approval of the benefit (in whole or in part) before the benefit may be obtained. A casual inquiry about benefits or the circumstances under which benefits might be paid are not considered a pre-service claim.

For a properly submitted pre-service claim, you will be notified by the Fund Office in writing of a decision within 15 days from receipt of the claim, unless additional time is needed. The time for response may be extended up to 15 days, if necessary, due to matters beyond our control. If an extension is necessary, you will be notified, before the end of the initial 15-day period, of the circumstances requiring the extension and the date by which the Fund Office expects to render a decision.

If an extension is needed because the Fund Office needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Fund Office then has 15 days to make a decision on the pre-service claim and notify you of the determination.

If you improperly file a pre-service claim, you will be notified as soon as possible but not later than 5 days after receipt of the claim of the proper procedures to be followed in filing a claim. You will only receive notice of an improperly filed pre-service claim if the claim does not include (i) your name, (ii) your specific medical condition or symptom and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is refilled properly, it will not constitute a claim.

Urgent care claims. An urgent care claim is any claim for care or treatment that must be processed quickly to prevent serious jeopardy to your life, health, or your ability to regain maximum function. Additionally, urgent care claims include those claims that, as determined by your provider, would subject you to severe pain that cannot be managed without the care or treatment requested under the claim.
Urgent care claims are determined by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a health care provider with knowledge of your medical condition determines is an urgent care claim within the meaning described above shall be treated as an urgent care claim.

For properly filed urgent care claims, you will be notified by the Fund Office of a decision as soon as possible taking into account the medical emergencies, but not later than 72 hours after receipt of the claim.

If an urgent care claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, you will be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You must provide the specified information within 48 hours from the receipt of this notification to supply the requested information. If you do not provide the information within that time, your claim will be denied.

During the period in which you are allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. This suspension will last from the date of the extension notice, for 48 hours, or until the date you respond to the request, whichever is earlier. Notice of the decision will be provided no later than 48 hours after receipt of the specified information or the end of the 48-hour period given for you to provide this information, whichever is earlier.

If you improperly file an urgent care claim, you will be notified as soon as possible but not later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing an urgent care claim. You will only receive notice of an improperly filed urgent care claim if your claim does not include (i) your name, (ii) your specific medical condition or symptom, and (iii) the specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute an urgent care claim.

Concurrent claims. A concurrent claim is a claim that is reconsidered after an initial approval has been made and results in a reduction, termination or extension of a benefit. In this situation, a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

A reconsideration of a benefit with respect to a concurrent claim that involves a reduction or termination of a previously approved benefit (other than by amendment or termination of the Plan) will be made as soon as possible but, in any event, early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request to extend approved urgent care treatment must be submitted in the same manner as urgent care claims. You will be notified by the Fund Office of a decision within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. If the claim is not made at least 24 hours prior to the expiration of the approved treatment, the request must be treated as an urgent care claim and decided according to the urgent care claim time frames. A request to extend approved treatment that does not involve an urgent care claim will be decided according to the pre-service or post-service claim time frames, whichever applies.

Post-service claims. A post-service claim is a claim that is not a pre-service, urgent care or concurrent claim (for example, a claim submitted for payment after the services and treatments have been rendered). Most claims under the Plan will be treated as post-service claims.

Ordinarily, you will be notified of decisions on post-service claims by the Fund Office within 30 days from the receipt of the claim. The Fund Office may unilaterally extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund Office. If an extension is necessary, you will be notified, before the end of the initial 30-day period, of the
circumstances requiring the extension and the date by which a benefit determination is expected to be rendered.

If an extension is required because the Fund Office needs additional information from you, the extension notice will specify the information needed. You will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the 45-day period in which you are allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until 45 days have passed or until the date you respond to the request, whichever is earlier. The Fund Office then has 15 days to make a decision on the claim and notify you of the determination.

Death, accidental death and dismemberment benefits claims. If your claim is denied, in whole or in part, the Fund Office will send you a written notice of the denial within 90 days after it receives your claim. If special circumstances require additional time to decide your claim, you will receive a written notice of the extension within 90 days after receipt of your claim explaining the special circumstances and the date when a benefit determination is expected. The extended due date cannot exceed 180 days from the date on which your claim originally was filed (in other words, the extension itself cannot exceed 90 days).

Notice of a claim decision. If your claim is denied, in whole or in part, you will be provided with a written notice of the decision to deny the claim. However, for urgent care claims and concurrent claims to extend approved urgent care treatment, you may be notified of a denial of a claim by telephone, provided that a written notice is provided to you not later than 3 days after the telephone notification. This notice will state:

- The specific reason(s) for the determination;
- Reference to the specific provision(s) of the Plan on which the determination is based;
- A description of any additional material or information necessary to complete the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits;
- A statement of your right to bring a civil action for your benefits under ERISA Section 502(a) following an adverse benefit determination on appeal; and
- For urgent care claims, the notice will describe the expedited appeal process applicable to urgent care claims.

In addition, with respect to claims other than for death, accidental death and dismemberment benefits:

- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive a statement that the rule is available upon request at no charge.
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive a statement that the explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim is available upon request at no charge.
Note: For urgent care claims and pre-service claims, you will receive a notice of the determination even when the claim is approved.

Requests for an appeal of a denied claim. If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you or your authorized representative may request the Board of Trustees to review your claims. This is your last recourse in the appeal process.

Your request for an appeal must be made in writing to the Board of Trustees and delivered or mailed to the Fund Office. However, appeals involving urgent care claims and any concurrent claims requesting extension of approved urgent care treatment may be made via telephone, fax or other available similarly expeditious (fast) method.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial and the reasons for your appeal. You should also include copies of any documents that the Trustees do not already have, which support your position. You are not required to cite all of the plan provisions that apply or to make “legal” arguments; however, you should clearly state why you believe you are entitled to the benefit you claim or why you disagree with a Fund policy, determination or action. The trustees can best consider your position if they clearly understand your claim, reasons and/or objections.

Your appeal must be made within the following time frames:

Medical, Pharmacy, Dental and Vision Claims

Your request for an appeal must be made within 180 days after you receive notice of the denial of claim. However, for a concurrent claim that involves a termination or reduction of previously approved care, the appeal must be rendered before the care is terminated or reduced.

Death, Accidental Death and Dismemberment Benefits Claims

You have 60 days from the day you received notice of the initial decision to appeal death, accidental death and dismemberment benefit claims.

Review (appeal) process. You have the right, upon request and free of charge, to receive reasonable access to and copies of all documents “relevant” to your claim. A document, record or other form of information is relevant if:

- It was relied upon in making the decision;
- It was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon);
- It demonstrates compliance with the administrative processes for ensuring consistent decision making; or
- With respect to claims other than death, accidental death and dismemberment benefits claims, it constitutes a statement of plan policy regarding the denied treatment or service.

The review of your claim will take into account all comments, documents, records and other information you submit relating to the claim (regardless of whether this information was submitted or considered in the initial benefit determination).

With respect to claims other than death, accidental death and dismemberment benefits claims, the
following will apply:

- Upon request, the Fund Office will identify medical or vocational experts (if any are available) that gave advice to the organization responsible for the initial determination of your claim, without regard to whether their advice was relied upon in deciding your claim.

- A different person will review your appeal than the one who originally denied the claim. The reviewer will not give deference to the initial decision to deny benefits. The appeals decision will be made on the basis of the entire record, including such additional documents and comments that you may submit.

- If your initial claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a healthcare professional with appropriate training and experience in a relevant field of medicine will be consulted.

Timing of notification of a decision on an appeal

- Appeals involving pre-service claims for medical, pharmacy, dental and vision benefits claims: You will be sent a notice of decision on appeal within 30 days of receipt of the appeal.

- Appeals involving urgent care claims for medical, pharmacy, dental and vision benefits claims: You will be sent a notice of a decision on appeal within 72 hours of receipt of the appeal.

- Appeals involving concurrent claims for medical, pharmacy, dental and vision benefits claims: You will be sent a notice of a decision on appeal for a concurrent claim that involves a termination or reduction of previously approved care before the care is terminated or reduced. Notice of a decision on appeal for a concurrent claim that involves an extension of care will be sent based on the time frames for urgent care, pre-service or post-service claim, whichever category applies to the appeal.

- Appeals involving all other claims: Ordinarily, decisions on appeals involving all other claims, including post-service claims for medical, pharmacy, dental and vision benefits claims, as well as claims involving death, accidental death and dismemberment benefits will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review.

If your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request.

In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension is necessary.

Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

**Notice of a decision on review of the appeal.** The decision on any appeal of your claim will be given to you in writing. The notice of a denial of a claim on appeal will state:
Decision of Trustees. The denial of an application or claim to which the right of review has been waived or the decision of the Board of Trustees, or its designees with respect to a petition for review, shall be final and binding upon all parties, including the applicant, claimant or petitioner and any person claiming under the application, claimant or petitioner, subject only to judicial review.

The provisions of this section shall apply to and include any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a “participant” or “beneficiary” of the Plan within the meaning of those terms as defined in ERISA.

Limitation on when a lawsuit may be started, or filed. You may not start or file a lawsuit to obtain benefits until after you have requested an appeal and a final decision has been reached on the appeal, or until the appropriate time frame described above has elapsed since you filed a request for an appeal and you did not receive a final decision or notice that an extension will be necessary to reach a final decision.

You may also pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act (ERISA) without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than three (3) years after the end of the year in which the services were provided.

Claims Filing

All medical and dental claims, whether submitted by you or your provider, should be mailed directly to the address listed on your medical identification card.

If the provider does not submit your claim for you, it is your responsibility to do so. Participants who do not receive an explanation of benefits within eight weeks of treatment should submit a copy of the claim that they received from the provider at the time service was rendered.

Generally, itemized claims should be filed with the Fund within 90 days of incurring covered charges. Late claims are difficult for the Fund Office to process. Claims not filed within twelve months of the
date of service, will not be accepted and will be denied.

An itemized claim or bill should include:

- The policy holder’s name, social security number or medical identification number;
- The patient’s name;
- The Physician’s or facility’s name, address and tax identification number;
- The dates of treatment or purchase;
- Medical CPT/hospital revenue codes, and dental ADA codes.
- The type of services (Physician’s office visit, Hospital, lab tests, etc);
- The charge made for each service;
- The condition (the diagnosis) for which the charge was incurred; and
- If due to an injury, indicate how, when, and where the injury occurred.

The Welfare Fund is equipped to accept your provider’s claims electronically. This method expedites the processing and payment of the claim. Electronic submission also eliminates lost claims due to the mail or delays in the manual processing of the claim.

However, if your provider cannot electronically submit the claim, the Fund can accept “paper” claims on the following forms.

- HCFA 1500 Form for Physician or medical provider services.
- UB-92 Form for the facility fees and some other services that were performed in a Hospital or facility.
- ADA Form for Dental Claims.

Participants are reminded that the aforementioned claim forms are the industry standard. Meaning that they have been created and approved by either the American Medical Association or the American Dental Association. Utilization of any other claim form or format by the provider or institution may cause a delay in the processing of the claim.

Provide all necessary information. Participants are responsible for the information on their claims. All participants should review the charges associated with the services that were provided at the time the treatment is rendered or completed. By doing so, you can avoid unnecessary delays in processing your claims by making sure that all the necessary information is included and correct on your claim.

A main reason for delays in processing of benefits is failure on the part of the providers furnishing supplies or services, and the person filing for benefits, to provide all the information needed to determine benefits.

Failure to supply complete information requires the Fund Office to send a request for additional information. This causes delays in processing your benefits.
Information most often omitted by participants and providers alike, in filing for benefits includes:

- Coverage under other group health plans provided through employment of other family members;
- How, when, and where an accidental injury occurred, and a complete description of the circumstances;
- Whether the injury was employment-related;
- Diagnosis of the condition for which the patient received treatment;
- The Physician’s tax identification number;
- Correct itemization for charges; and
- Verification of a dependent’s status, if applicable.

**Assignment of Benefits.** If you want the Fund to pay your medical provider directly, sign the “Assignment of Benefits” portion of the claim form. Then the Fund makes direct payment to the provider and sends you an explanation of benefits (EOB) so you know what was paid.

**Coverage Under More Than One Plan.** If you or an eligible dependent has coverage under two or more health plans, this Fund’s benefits will be coordinated with the other insurer according to the provisions outlined within the section of this summary plan description book titled “Coordination of Benefits”.

If you or an eligible dependent do have coverage under two or more health plans, be sure to include the name of the other health plan(s) on your claim form, along with the explanation of benefits from the primary carrier.

Additionally, if a participant is covered by Medicare and/or another plan, they must attach a copy of the itemized bill relating to the health service provided and a copy of any explanation of benefits (EOB) from the other provider. Both the bill and the EOB must be submitted.

If Medicare is you or your dependents’ primary insurer, ask your provider to bill Medicare for you. When Medicare makes its payment, you will receive an EOB from Medicare.

You must submit a copy of the Medicare EOB, along with an itemized statement from your provider to the Fund so benefits can be coordinated with payment from Medicare.

Please do not forward the itemized statement to the Fund until you have the Medicare EOB. If you do, the Fund Office will send you a letter requesting the Medicare EOB before you file a claim.

**Failure to submit requested information and documentation.** You have forty-five (45) days after you receive the notification requesting additional information to submit said information into the Fund. If the information and/or supporting documentation is not received within this period, the claim will be denied and payment for the service or treatment will remain the responsibility of the participant.
Claim Flow Process Overview

In order to provide you with a general idea of the claim adjudication process the following flow chart has been provided.

Participants are reminded that several factors can affect the process of their claims. Such factors would include, but are not limited:

- Whether or not the bill submitted is a "clean claim";
- Whether or not the individual was eligible for benefits at the time the claim was incurred; or
- Whether or not a request for additional information or verification is satisfied, or satisfied in a timely manner.
In 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA. This law generally requires that most employers with group health plans offer employees and their covered dependents the opportunity to temporarily continue their health care coverage at group rates when coverage under the Plan would otherwise end.

If you and/or your eligible dependents are covered under the medical Plan, you and/or your dependents can continue coverage for a time if coverage ends for one of the several reasons outlined in this section. COBRA continuation coverage is administered through the Plan at the following address:

The Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D
265 West 14th Street, Room 500
New York, NY 10011
(212) 255–7657

Entitlement to COBRA Continuation Coverage: When (called the Qualifying Event) and For How Long

A qualified beneficiary is entitled to choose COBRA continuation coverage when a qualifying event occurs, and as a result of that qualifying event, that person’s health care coverage ends, either as of the date of the qualifying event or as of some later date.

Qualified Beneficiary. Under the law, a qualified beneficiary is any participant, spouse or dependent child of a participant or retiree who was covered by the Plan when a qualifying event occurs, and who is therefore entitled to choose COBRA continuation coverage. A child who becomes a dependent child by birth, adoption or placement for adoption with the covered employee or retiree during a period of COBRA continuation coverage is also a qualified beneficiary. A covered employee or retiree during a period of COBRA continuation coverage is also a qualified beneficiary. A person who becomes the new spouse of an employee or retiree during a period of COBRA continuation coverage is not a qualified beneficiary.

Qualifying Event. Qualifying events are those shown in the subsequent chart. Qualified beneficiaries are entitled to COBRA continuation coverage when qualifying events (which are specified in the law) occur, and as a result of the qualifying event, coverage of that qualified beneficiary ends. A qualifying event triggers the opportunity to elect COBRA when the covered individual loses health care coverage under the Plan. If a covered individual has a qualifying event but does not lose health care coverage under the Plan (for example, the employee continues working even though entitled to Medicare), then COBRA is not yet offered.

Maximum period of COBRA continuation coverage. The maximum period of COBRA continuation coverage is generally 18 months or 36 months, depending on which qualifying event occurs. The period of COBRA continuation coverage is measured from the time the qualifying event occurs. The 18-month period of COBRA continuation coverage may be extended for up to 11 months under certain circumstances (described in another section of this chapter on extending COBRA in cases of disability). That period may also be cut short for the reasons set forth in “Termination of COBRA,” which appears later in this section.
Qualifying Events and Maximum Periods of Continuation of Coverage

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Employee</th>
<th>Spouse</th>
<th>Dependent Child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee terminated (for reason other than gross misconduct)</td>
<td>18 Months</td>
<td>18 Months</td>
<td>18 Months</td>
</tr>
<tr>
<td>Employee reduction in hours worked (making employee ineligible for the same coverage)</td>
<td>18 Months</td>
<td>18 Months</td>
<td>18 Months</td>
</tr>
<tr>
<td>Employee dies</td>
<td>N/A</td>
<td>36 Months</td>
<td>36 Months</td>
</tr>
<tr>
<td>Employee becomes divorced</td>
<td>N/A</td>
<td>36 Months</td>
<td>36 Months</td>
</tr>
<tr>
<td>Employee becomes entitled to Medicare</td>
<td>N/A</td>
<td>36 Months</td>
<td>36 Months</td>
</tr>
<tr>
<td>Dependent child ceases to have dependent status</td>
<td>N/A</td>
<td>N/A</td>
<td>36 Months</td>
</tr>
</tbody>
</table>

Each qualified beneficiary, with respect to a particular qualifying event, has an independent right to elect COBRA continuation of coverage. For example, both you and your spouse may elect continuation of coverage, or only one of them. A parent or legal guardian may elect continuation coverage for a minor child.

**Notice you must give the Welfare Fund.** As a covered member or qualified beneficiary, you must provide the Welfare Fund with timely notice of certain qualifying events. Those qualifying events include the following:

- The divorce of a covered member from his or her spouse.
- A beneficiary ceasing to be covered under the Plan as a dependent child of a participant.
- The occurrence of a second qualifying event 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, entitlement to Medicare, divorce or child losing dependent status.

In addition to these qualifying events, there are two other situations where a covered employee or qualified beneficiary is responsible for providing the Welfare Fund with notice within the time frame noted in this section:

- A qualified beneficiary entitled to receive COBRA coverage with 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 days 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.
- The Social Security Administration determines that a qualified beneficiary is no longer disabled.

You must make sure that the Welfare Fund is notified of any of the occurrences listed above. Failure to provide this notice in the form and within the time frames described below may prevent you and/or your dependents from obtaining or extending COBRA coverage.
How a notice should be provided. Notice of any of the five situations listed above must be provided in writing. You may send a letter to the Welfare Fund, containing the following information: your name, which of the five events listed above you are providing notice of, the date of the event, and the date on which the participant and/or beneficiary will lose coverage.

When a notice should be sent. If you are providing notice due to a divorce or a dependent losing eligibility for coverage or a second qualifying event, you must send the notice no later than 60 days after (1) the date upon which coverage would be lost under the Plan as a result of the qualifying event, (2) the date of the qualifying event, or (3) the date on which the qualified beneficiary is informed through the furnishing of a summary plan description or initial COBRA notice of the responsibility to provide the notice and the procedures for providing this notice to the Welfare Fund.

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 letter of the date of the determination by the Social Security Administration that you are no longer disabled.

Who can provide a notice. The covered employee, qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or qualified beneficiary, may provide notice. 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, her spouse and her child are all covered by the Plan, and the child ceases to become a dependent under the Plan, a single notice sent by the spouse would satisfy this requirement.

In the event of the employee’s death, the employee’s family should notify the Welfare Fund promptly and in writing if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in the transmittal of information to the Welfare Fund.

Notice when you become entitled to COBRA continuation coverage. When your health care coverage ends—because your employment terminates, your hours are reduced so that you are no longer entitled to coverage under the Plan, you die, become entitled to Medicare, or when the Welfare Fund is notified that a dependent child lost dependent status or you are divorced—the Welfare Fund will give you, your spouse and/or your covered dependents notice of the date on which your coverage ends, as well as the information and forms needed to elect COBRA continuation coverage. Under the law, you and/or your covered dependents will then have only 60 days from the date of receipt of that notice, to enable you and/or them to apply for COBRA continuation coverage.

If you and/or any of your covered dependents do not choose COBRA continuation coverage within 60 days after receiving notice, you and/or they will have no group health coverage from the Plan after the date coverage ends.

Where you or your dependents have provided notice to the Welfare Fund of a divorce, a beneficiary ceasing to be covered under the Plan as a dependent, or a second qualifying event but are not entitled to COBRA, the Welfare Fund will send you a written notice stating the reason why you are not eligible for COBRA.

Coverage that will be provided if you elect continuation coverage. If you and/or your dependent(s) choose COBRA continuation coverage, the Plan is required to provide coverage that is identical to the current coverage under the medical and/or dental plan that is provided for similarly situated employees or family members.

Please note that C.O.B.R.A., coverage does not include the following benefits:

- The Vision Benefit,
- The Accidental Dismemberment Benefit or,
- The Death Benefit
The same rules about dependent status and qualifying changes in family status that apply to active employees will apply to you and/or your dependent(s).

If, during the period of COBRA continuation coverage, the Plan’s benefits change for active employees, the same changes will apply to you and/or your dependent(s).

Adding a spouse or new dependent. If, during the period of COBRA continuation coverage, you marry, have a newborn child, or have a child placed with you for adoption, that spouse or dependent child may be enrolled for coverage for the balance of the period of COBRA continuation coverage on the same terms available to active employees. You will need to enroll that spouse or child for coverage within 30 days after the marriage, birth, adoption, or placement for adoption. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA continuation coverage.

Loss of other group health plan coverage. If, while you are enrolled for COBRA continuation coverage, your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA continuation coverage. The spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA continuation coverage under another plan, termination as a result of the loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll your spouse or dependent within 30 days after the termination of the other coverage. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA continuation coverage.

When the Maximum Period of Continuation Coverage May Change

Second qualifying event. If your continuation coverage (according to the table) is for a maximum period of 18 months, and during that period, another qualifying event takes place that would otherwise entitle a spouse or dependent child to a 36-month period of continuation coverage, the 18-month period will be extended for that spouse or dependent child. The total period of coverage for any spouse or dependent child will never exceed 36 months from the date of the first qualifying event.

For example, if you terminated employment and elected COBRA continuation coverage for 18 months for yourself and your covered spouse and/or dependent child (ren), and you died during that 18-month period, the continuation coverage for your spouse and/or dependent child (ren) could be extended for the balance of 36 months from the date your employment terminated.

Entitlement to Social Security disability income benefits. If you, your spouse or any of your covered dependent children are entitled to COBRA continuation coverage for an 18-month period, that period can be extended for the covered person who is determined to be entitled to Social Security disability income benefits, and for any other covered family member, for up to 11 additional months if:

- The disability occurred on or before the start of COBRA continuation coverage, or within the first 60 days of COBRA continuation coverage;
- The disabled covered person receives a determination of entitlement to Social Security
disability income benefits from the Social Security Administration within the 18-month COBRA continuation period; and

- You or the disabled person notifies the Welfare Fund of such a determination within that 18-month period.

This extended period of COBRA continuation coverage will end at the earlier of the end of 29 months from the date of the qualifying event or the date the disabled individual becomes entitled to Medicare.

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

In no case is an employee whose employment has been terminated or had a reduction in hours entitled to COBRA continuation coverage for more than a total of 18 months (unless the employee is entitled to an additional period of up to 11 months of COBRA continuation coverage on account of disability as described in the above section). As a result, if an employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

In no case is anyone else entitled to COBRA continuation coverage for more than a total of 36 months.

What you must pay for COBRA continuation coverage. You, your covered spouse and/or your covered dependent child (ren) will have to pay the full cost of the coverage during the COBRA continuation period.

The amount you, your covered spouse and/or your covered dependent child (ren) must pay for your COBRA continuation coverage will be payable monthly. There will be an initial grace period of 45 days to pay the first amounts due, starting with the date continuation coverage was elected. Thereafter, monthly premium payments are due on the first of every month. COBRA, participant’s that are having difficulty making payment on time will be allowed a thirty day grace period beginning from the day payment should have been received. However, if payment of the amounts due is not received by the end of the applicable grace period, the COBRA continuation coverage will terminate.

Confirmation of coverage before election or payment of the cost of COBRA continuation coverage. If a health care provider requests confirmation of coverage and you, your spouse or dependent child (ren) have elected COBRA continuation coverage and the amount required for COBRA continuation coverage has not been paid while the grace period is still in effect or you, your spouse or dependent child (ren) are within the COBRA election period but have not yet elected COBRA, then COBRA continuation coverage will be confirmed, but with notice to the health care provider that the cost of the COBRA continuation coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA continuation coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Termination of COBRA Continuation Coverage

COBRA continuation coverage may be terminated if:

- Medical or dental coverage is no longer provided to any similar employees or participants;
- You do not pay the applicable premium for your COBRA continuation coverage on time;
● The covered person enrolls in Medicare; or

● The covered person is or becomes covered under another group health plan that does not contain an exclusion or limitation that applies to any pre-existing condition of the covered person.

If any covered person enrolls in Medicare, the COBRA continuation coverage of that person ends, but the COBRA continuation coverage of any covered spouse or dependent child of that covered person will not be affected.

If continuation coverage is terminated before the end of the maximum coverage period, the Welfare Fund will send you a written notice as soon as possible following the determination that continuation coverage will terminate. The notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

Other information about COBRA continuation coverage. If the coverage provided by the Plan is changed in any respect for active Plan participants, those changes will apply at the same time and in the same manner for everyone whose coverage is continued as required by COBRA. If any of those changes result in either an increase or decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued as required by COBRA as of the effective date of those changes.

Keeping the Welfare Fund informed of address changes. In order to protect your family’s rights, you should keep the Welfare Fund 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 Welfare Fund.

Certification of coverage when coverage ends. Both when coverage under the Plan initially ends and when your COBRA coverage ends, the Welfare Fund will provide you and/or your covered dependents with a certificate of coverage that indicates the period of time you and/or they were covered under the Plan. If, within 62 days after your coverage under the Plan ends, you and/or your covered dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered dependents, a health insurance policy, you may need this certificate to reduce any exclusion for pre-existing conditions that may apply to you and/or your spouse and dependent children in that group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under the Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered dependents) by first class mail shortly after your (or their) coverage under the Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage has terminated.

In addition, a certificate will be provided to you and/or any covered dependent upon a receipt of a request for such a certificate—if that request is received by the Welfare Fund within two years after the later of the date your coverage under the Plan ended or the date COBRA continuation coverage ended, if the request is addressed to:

The Welfare Fund of the International Union of Operating Engineers,
Local 15, 15A, 15C and 15D
265 West 14th Street, Room 500
New York, NY 10011
(212) 255–7657
Communications for Benefit Updates and Reminders

Communications for benefit updates will be posted on the Funds website or other website disclosed to you and/or mailed to you or delivered to the e-mail address you provide.

Delivery of Electronic Communications: Any Communication made by electronically posting it to the Fund’s website will be considered sent at the time it is publicly available. If the Communication is posted to the web site, then it will be deemed to have been received by you no later than five (5) business days after the Fund posts the Communication to the web site.

Any electronic Communication sent by e-mail is considered to be sent at the time that it is directed by the Fund’s e-mail server to the e-mail address provided by the participant. The e-mail communication will be deemed to have been received by you, whether or not you retrieve the email by opening it.

Reminder notices are sent to the participants strictly as a courtesy. Future reminder notices will be at the discretion of the Fund. Communication of the reminder notices will be posted on the Funds website or other website disclosed to you and/or delivered to the e-mail address you provide.

It is the responsibility of the participant to provide the Fund Office with their current e-mail address. The Fund will not be responsible for misdirected e-mails or returned emails because of the failure of the participant to update his or her email address.

Compliance Based Health Plan/Annual Health Maintenance Routine

Unhealthy behaviors are like gravity. Gravity doesn't announce itself. It just is. However, if you violate the laws of gravity you have consequences. The same can be said with the laws of health.

Despite advances in medicine, many illnesses, accidents or diseases still result in disability and sometimes death. Fortunately, many of these maladies can be avoided completely or their severity reduced by maintaining healthy behaviors and by adhering to an annual health maintenance program.

Left unchecked, unhealthy behaviors could affect your Benefit Plan in one or more of the following ways:

1. Increased hourly premiums, and/or
2. Modifications (reductions) in existing plan benefits, and/or
3. Modifications in coverage periods

Obviously, no one wants to see these actions taken. Unless, each of us incorporate a healthier lifestyle into our daily routine, the Trustees may be forced to integrate “measures of compliance” into the future benefit structure of the Plan.

These amendments may include, but are not limited to:

- Mandatory, annual individual health maintenance routines. These programs may be designed around age or gender-appropriate guidelines for well care and for condition management, to which each participant is obligated to adhere; and,
- Individual financial obligations or increased cost sharing based on the participants' compliance efforts.
Each day brings new opportunities. What steps can be taken daily to ensure a healthier you?

1. Reflect upon how your current health is affecting the various areas of your life.
2. Consider how yours and your family’s unhealthy daily actions create unnecessary and unhealthy reactions; be it physical, mental and / or monetary.
3. Seek Guidance. It is available if you choose to make improvements. Today, it is easier than ever to get the information and assistance you require to make the modifications for a healthier tomorrow.
4. Don’t wait!

As a self-insured Benefit Fund, we are all responsible for its financial strength. By consistently making strides toward improving our daily health, and by becoming more informed to the consequences of our daily actions, we all have the potential to improve our physical, mental and monetary well being.

Coordination Of Benefits-Coverage Under More Than One Plan

When a member is covered by more than one insurance plan, health insurers coordinate benefits by determining who is the primary and secondary payer. This prevents duplication of payments and overpayments. Consequently, the benefits payable to you under the Plan are “coordinated” with any benefits payable to or on behalf of you or your dependents for the same expenses from other health plans or Medicare.

The Fund has adopted the “birthday rule” with respect to the coordination of benefits in determining which plan shall be the primary payer when two group health care plans cover the same dependent child. When this occurs, the plan that pays first is the one covering the parent whose date of birth occurs earlier in the year. Only the month and day are considered when determining whose birthday falls earlier.

If a participant holds a contract for a group insurance plan and is listed as a dependent on another insurance plan, the plan for which the participant is a contract holder is primary.

For covered dependent children with separated or divorced parents, if a court has established which parent is responsible for the child’s health care expenses, that parent’s plan is primary. When financial responsibility has not been established, the plan covering the parent with legal custody is primary.

A group plan that does not have a coordination of benefits provision will be primary over the Plan.

If a member holds two or more group insurance plans, the policy that considers the member an active employee is primary. If both of the member’s policies are active, the policy that has been active longer or longest is primary.

Under the coordination of benefits provision, if you or any of your dependents are covered by more than one health plan or covered under Medicare, payment or reimbursement will be up to but not more than 100% of the Welfare Fund’s allowable expenses.

The payment or reimbursement will be coordinated so that the total amount payable does not exceed 100% of the expenses incurred and there is no duplication of any benefits provided.
Co-Surgeons

Benefits are available for one co-surgeon per inpatient operative session. The complexity of the surgical procedure will determine if co-surgeon services are appropriate and covered.

Participating provider charges will be subject to the deductible, and payable at the negotiated rate.

Non-participating provider charges will be subject to the deductible and payable at 80% of 50% (or half) of the Fund’s usual, customary and reasonable fee schedule for the surgical procedure.

If deemed medically necessary, reimbursement for each additional non-participating surgeon’s services will be paid by using the following formula:

The amount of the Fund’s reasonable and customary fee schedule for the surgical procedure divided by the number of surgeons multiplied by 80%.
Death Benefit 15 – 15A

Provided you met the basic eligibility criteria for this benefit, your beneficiary will receive a death benefit of $35,000 should you die either on or off the job. This is a taxable benefit for which your beneficiary will receive an IRS 1099 form at the end of the year.

If the participant should die as result of an accidental death, either on or off the job, your beneficiary will receive a death benefit of $70,000. This is a taxable benefit for which the beneficiary will receive an IRS 1099 form at the end of the year.

Initial Death Eligibility Criteria

For new members and employees joining the International Union of Operating Engineers, Local 15, 15A, and for those being reinstated from “suspension status” or “withdrawal status”, there is a waiting period of six months in which you are required to perform at least 375 hours of unit work in order to be eligible for the benefits outlined in this section. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

On Going Death Benefit Eligibility Criteria for Local 15 - 15A

- If you work at least 112.5 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next benefit period.

- If you work at least 225 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next two benefit periods.

- If you work at least 337.5 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next three benefit periods.

Death Benefit 15C

For new members and employees joining the International Union of Operating Engineers, Local 15, 15A, 15C and 15D, and for those being reinstated from “suspension status” or “withdrawal status”, there is a waiting period of six months in which you are required to perform at least 375 hours of unit work in order to be eligible for the benefits outlined in this section. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

On Going Death Benefit Eligibility Criteria for Local 15 - C

- If you work at least 112.5 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next benefit period.

- If you work at least 225 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next two benefit periods.

- If you work at least 337.5 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next three benefit periods.

Death Benefit For 15-C Participants Working Under the Sims / Hugo Neu, Bronx Metal Recycling Division Agreements

For new members and employees joining the International Union of Operating Engineers, Local 15C, and for those being reinstated from “suspension status” or “withdrawal status”, that work under this agreement there is a waiting period of six months in which you are required to perform at least
458 hours of unit work in order to be eligible for the benefits outlined in this section. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

On Going Death Benefit Eligibility Criteria for Local 15 – C Participants working under the Sims / Hugo Neu, Bronx Metal Recycling Division Agreement

- If you work at least 137.5 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next benefit period.
- If you work at least 275 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next two benefit periods.
- If you work at least 412.50 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next three benefit periods.

Death Benefit For 15-C Participants Working Under the Small Tool Agreements

For new members and employees joining the International Union of Operating Engineers, Local 15C, and for those being reinstated from “suspension status” or “withdrawal status”, that work under this agreement there is a waiting period of six months in which you are required to perform at least 393 hours of unit work in order to be eligible for the benefits outlined in this section. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

On Going Death Benefit Eligibility Criteria for Local 15 – C Participants working under the Small Tool Agreements

- If you work at least 117 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next benefit period.
- If you work at least 236 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next two benefit periods.
- If you work at least 354 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next three benefit periods.

Death Benefit 15D

For new members and employees joining the International Union of Operating Engineers, Local 15D, and for those being reinstated from “suspension status” or “withdrawal status”, there is a waiting period of six months in which you are required to perform at least 375 hours of unit work in order to be eligible for the benefits outlined in this section. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

On Going Death Benefit Eligibility Criteria for Local 15 - D

- If you work at least 112.5 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next benefit period.
- If you work at least 225 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next two benefit periods.
- If you work at least 337.5 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next three benefit periods.
Death Benefit For 15-D Participants Working Under the Consultant Surveyor Agreement

For new members and employees joining the International Union of Operating Engineers, Local 15D, and for those being reinstated from “suspension status” or “withdrawal status”, that work under the Consultant Surveyor Agreement, there is a waiting period of six months in which you are required to perform at least 474 hours of unit work in order to be eligible for the benefits outlined in this section. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

On Going Death Benefit Eligibility Criteria for Local 15 – D Participants working under the Consultant Surveyor Agreement

- If you work at least 142 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next benefit period.
- If you work at least 284 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next two benefit periods.
- If you work at least 427 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next three benefit periods.

Death Benefit For 15-D Participants Working Under the Nelson and Pope Agreement

For new members and employees joining the International Union of Operating Engineers, Local 15D, and for those being reinstated from “suspension status” or “withdrawal status”, that work under the Nelson and Pope, there is a waiting period of six months in which you are required to perform at least 529 hours of unit work in order to be eligible for the benefits outlined in this section. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

On Going Death Benefit Eligibility Criteria for Local 15 – D Participants working under the Nelson and Pope Agreement

- If you work at least 159 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next benefit period.
- If you work at least 317 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next two benefit periods.
- If you work at least 476 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next three benefit periods.

Death Benefit – For Owner Operators

For new Owner Operators joining the International Union of Operating Engineers, Local 15-15A, 15C and 15D, and for those being reinstated from “suspension status” or “withdrawal status”, there is a waiting period of six months in which you are required to perform at least the minimum hours of unit work (listed below) in order to be eligible for the benefits outlined in this section. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

<table>
<thead>
<tr>
<th>Agreement</th>
<th>Minimum Required Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 – 15A</td>
<td>375</td>
</tr>
<tr>
<td>15-C</td>
<td>375</td>
</tr>
<tr>
<td>15-D</td>
<td>375</td>
</tr>
<tr>
<td>15-D Consultant &amp; Surveyor</td>
<td>474</td>
</tr>
</tbody>
</table>
On Going Death Benefit Eligibility Criteria for Owner Operators

- If you work at least 306 hours in a benefit period, your beneficiary will be eligible for the death benefit for the next benefit period.

On Going Death Benefit Eligibility Criteria for Owner Operators working under the Consultant Surveyor Agreements.

- If you work at least 387 hours under the Consultant and Surveyor agreement in a benefit period, your beneficiary will be eligible for the death benefit for the next one benefit periods.

Coverage for the death benefit will continue:

- For a period of 31 days after termination of eligibility; or
- For as long as you are totally and uninterruptedly disabled, while you are covered under the Plan; or
- The entire term you are serving your country in military service. However, the death benefit will not be paid if death should result from any act of war or an internal conflict, insurrection or rebellion of any country.

Benefits will not be paid for:

- Suicide or self-inflicted injury.
- Noncommercial (non-work related) air travel.
- Death as a result of committing a felony.
- Any act of war or an internal conflict, insurrection or rebellion of any country.

Payout.

The monies will be given to the beneficiary on file with the Welfare Fund at time of death. If no beneficiary is listed, then the benefit will be paid in the following manner:

1. To your surviving spouse; or
2. To the individual’s estate.

Death benefit applications or notifications received 12 months or greater from the date of death of the member will not be considered and the benefit will be forfeited.

Claimants that cannot provide proper documentation to substantiate their relationship with the deceased member within the 12-month period from the date of death will forfeit their right to the death benefit. Any monies owed would then be paid to the estate of the member.

Deductible

Medical Deductible

The Fund requires that each participant satisfy a $100 dollar major medical deductible per calendar year. This deductible applies to both in-network providers and out-of-network providers.

The $100 deductible applies only once in a calendar year, even though the covered individual may have several different accidents or sicknesses.
Unless otherwise indicated in this book, the annual deductible will be applied toward any medical claim (physician, laboratory, durable medical goods, diagnostic testing, etc.) that is processed first in the calendar year.

The Fund will not make any payment toward any claim until the deductible has been met.

Note: For calculation purposes, the Fund will utilize the claim’s processed date as the trigger date for the calculation of the participant’s deductible.

Pharmaceutical Deductible

The Fund requires that each participant satisfy a $25.00 deductible per calendar year. This deductible is separate and distinct from the major medical deductible explained previously. To learn more about your pharmaceutical benefits, please refer to the section of this book titled “Pharmaceutical Benefits”

Dental Benefits

Dental benefits will be paid at 100% of the fee schedule to a maximum of $2,000 per person, per calendar year.

Dental benefits for services performed by a licensed dentist will be paid in accordance with the Welfare Fund’s schedule of dental care benefits.

No benefits will be paid in excess of the amount charged, nor will a licensed dentist be paid for any benefit if the patient does not incur an actual charge.

No payment will be made for any amounts for which you are not legally liable in the absence of coverage by the Fund.

Coverage for dental conditions that existed prior to becoming eligible for this benefit will be provided, but no payment will be made for any dental work performed prior to your becoming eligible for this benefit.

Dental work which commences after the termination of coverage by the Fund is not covered.

An ADA claim form must be completed and returned to the Fund Office within 30 days after all dental work is finished.

No payment will be made for accidents or illnesses covered by Workers’ Compensation, nor for treatment received in hospitals, clinics, etc., operated by federal, state, county or municipal agencies.

The specific dental benefits available to you appear on the table on the following page.

Schedule of Dental Benefits for Active Members

(Services not contained within the listed schedule of benefits will not be covered under this plan)

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Maximum Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each person in the family, the combined maximum allowance for dental in a calendar year</td>
<td>$2,000</td>
</tr>
<tr>
<td>Examinations allowed per year</td>
<td>2 Times per calendar year, up to $50 per Exam</td>
</tr>
<tr>
<td>X-ray</td>
<td>4 X-rays are allowed per calendar year, with up to $50 toward each set of X-rays</td>
</tr>
<tr>
<td>Semi-annual cleaning or scaling of teeth</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Fillings (silver, amalgam, synthetic, acrylics) per tooth</td>
<td>Up to $36</td>
</tr>
<tr>
<td>Single surface</td>
<td>Up to $36</td>
</tr>
</tbody>
</table>
### TREATMENT

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Maximum Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two surfaces</td>
<td>Up to $56</td>
</tr>
<tr>
<td>Three surfaces</td>
<td>Up to $76</td>
</tr>
<tr>
<td>Four surfaces</td>
<td>Up to $76</td>
</tr>
<tr>
<td>Extractions, each tooth</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Root canal, each canal</td>
<td>Up to $250</td>
</tr>
<tr>
<td>Periodontal root planning and scaling, each quadrant</td>
<td>Up to $50 twice a year</td>
</tr>
<tr>
<td>Periodontal maintenance once per calendar year</td>
<td>Up to $100</td>
</tr>
<tr>
<td>Porcelain/gold inlays, each tooth</td>
<td>Up to $175</td>
</tr>
<tr>
<td>Porcelain veneer laminate</td>
<td>Up to $76</td>
</tr>
<tr>
<td>Post and Core</td>
<td>Up to $150</td>
</tr>
<tr>
<td>Caps, crowns, jackets, each tooth</td>
<td>Up to $440</td>
</tr>
<tr>
<td>Child’s crowns</td>
<td>Up to $190</td>
</tr>
</tbody>
</table>

### DENTURES

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Maximum Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial dentures</td>
<td>Up to $440 each tooth, up to $1,320 maximum per jaw</td>
</tr>
<tr>
<td>Full upper or lower</td>
<td>Up to $500 each denture, once every two years</td>
</tr>
<tr>
<td>Reline and addition of new material to tooth</td>
<td>Up to $100 each procedure</td>
</tr>
<tr>
<td>Repair and/or replacement of teeth</td>
<td>Up to $90 each tooth, maximum three teeth per repair</td>
</tr>
</tbody>
</table>

### ORAL SURGERY

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Maximum Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex extractions (where flap repair or sutures are required)</td>
<td>Up to $100 per tooth</td>
</tr>
<tr>
<td>Impaction (tooth embedded in jawbone)</td>
<td>Up to $130 per tooth</td>
</tr>
<tr>
<td>Gingivectomy/osseous surgery</td>
<td>Up to $250 per quadrant</td>
</tr>
<tr>
<td>Removal of cysts, including tooth removal</td>
<td>Up to $120</td>
</tr>
<tr>
<td>Trimming of bone, each jaw</td>
<td>Up to $120</td>
</tr>
<tr>
<td>Anesthesia – for oral surgery only</td>
<td>Up to $150</td>
</tr>
<tr>
<td>Incision and drainage of abscess</td>
<td>Up to $120</td>
</tr>
<tr>
<td>Removal of root tip, (root apicoectomy) each tip</td>
<td>Up to $180</td>
</tr>
</tbody>
</table>

### ORTHODONTIA (this benefit is only provided to unmarried, eligible dependent children)

The Fund will allow a lifetime allowance of $4,250.00 toward a child’s orthodontia treatment. Provider charges will be subtracted from this allowance as claims are presented.

A participant’s orthodontia benefit cannot be combined with another participants benefit to create a larger benefit.

Payments made toward orthodontia treatments under the previous schedule are final. No additional payments will be made for treatments incurred prior to June 1, 2006, unless otherwise authorized by the Administrator of the Plan.

Note: Fluoride treatments, dental implants and sealants are not covered under this plan.

### Diabetes

Diabetes is not only recognized as one of the leading causes of death and disability in the United States, it is also associated with long-term complications that affect almost every part of the body. This disease often leads to blindness, heart and blood vessel disease, stroke, kidney failure, amputations, and nerve damage.
Diabetic Management

Often, having a team of physicians or specialists can improve diabetes care. All participants with diabetes should see a health care provider who will help them learn to manage their diabetes and who will monitor their diabetes control. Your team of physicians might include:

- A physician such as an internist, a family practice doctor, or a pediatrician;
- An endocrinologist (a specialist in diabetes care);
- A dietitian, who is a certified diabetes educator;
- A podiatrist (for foot care);
- A cardiologist (for heart care), and
- An ophthalmologist (for eye care)

The cost associated with the purchase of the following will be covered under the participant’s lifetime major medical allowance:

- Insulin pump;
- Monthly infusion sets;
- Lancets;
- Test strips;
- Needles, and
- Insulin

Prior approval is required. Participating provider charges will be subject to the deductible and payable at 100% of the negotiated rate.

Prior approval is required. Non-participating provider charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule.

Diagnostic Testing

The Fund provides benefits for the services necessary for the diagnosis and treatment of a covered medical condition. Services include, but are not limited to, X-ray, examinations, imaging services such as MRIs and cat scans, radiology imaging, mammography’s, laboratory services and other diagnostic services.

WARNING: The Fund fee schedule for many diagnostic procedures is predicated upon these services being performed within a freestanding facility, as opposed to a hospital. Therefore, the fees are often payable at a lower rate than a hospital may charge.

While you still may utilize a hospital for diagnostic testing, be aware that any non-emergency diagnostic claim that contains the Tax-Identification number of a hospital will be subject to the deductible and paid at 80% of the Funds usual, customary and reasonable fee schedule.

This would included, but is not limited to circumstances where:

1. As a matter of convenience for your physician, he/ she had these tests performed in a hospital setting as opposed to a freestanding ambulatory site.
2. As a matter of convenience for you, you chose to have these tests performed within a hospital.
3. Where the physician sent you to the hospital for these diagnostic tests, unless it was an issue relating to medical necessity, to which the Fund reserves the right to require your physician to substantiate.
4. Where the claims associated with the diagnostic services you received in your physician office are being presented for payment with the Tax Identification number of a regional hospital, making it...
appear that the services you received were performed within the hospital facility itself. Today, more and more physicians are leasing diagnostic equipment from hospitals. Although, the diagnostic services were performed in a physician’s office, the leasing arrangement allows for your claims to be billed by the owner of the equipment (the hospital) which then allows your diagnostic claims to be billed / reimbursed at a much higher rate.

You can avoid most out of pocket costs if you:

1. Inform your physician that, unless there is medical necessity you must have your diagnostic testing performed in a participating facility that is non-hospital related in order to avoid having to pay any co-insurance.

2. Become familiar with the in-network freestanding diagnostic testing facilities available in your geographical area and days and time of their operation.

Tilt table testing and pulmonary function: Diagnostic testing for these services that are performed in a participating hospital will be subject to the deductible, then paid 100% of the contracted rate. Testing performed in a non-participating hospital or facility will be subject to the deductible, then paid at 80% of the Fund’s reasonable cost.

Pre-Surgical testing: Diagnostic tests prescribed by your physician and completed in the same hospital as the scheduled surgery will be covered in full, provided the surgery takes place within 7 days of testing and provided tests are related to, and necessary for, diagnosis and treatment of the conditions requiring surgery. The deductible does not apply.

Breast Sonograms and/or Mammograms: Participants requiring breast sonograms and/or mammograms please refer to the section of this handbook titled breast sonogram or the section titled Mammograms.

Reminder: Diagnostic testing performed in a participating free standing facility other than a hospital, will be subject to the deductible and payable at 100% of the negotiated rate.

All diagnostic testing performed either in a participating hospital or a non-participating freestanding facility will be subject to the deductible and paid at 80% of the Fund’s usual, customary and reasonable fee schedule.

If you have any doubt concerning how your diagnostic tests will be paid, call the Fund Office.

Dialysis for Kidney Failure

Inpatient

Hemodialysis or peritoneal dialysis is covered at 100% of the Fund’s negotiated rate while the Fund participant is a registered bed patient in an approved* participating hospital only.

Outpatient

In the home – Necessary supplies required for home dialysis treatment as well as rental costs of the required equipment is covered when supplied by an approved* participating durable medical supplier.

Outpatient treatments performed in a hospital or freestanding facility will be covered at 100% of the Fund’s negotiated rate when the facility’s program is approved by the appropriate governmental authorities and is an approved* participating hospital or facility only.

*Approved participating hospital or facilities are those entities that have been deemed a center of excellence for this condition. To obtain a list of centers of excellence for this condition, please call member services at (212)-255-7657.

Participants who are on dialysis or are in need of dialysis for kidney failure should know that this illness necessitates the utilization of case management. As such, the Fund reserves the right to direct medical professional to monitor your treatment through its Catastrophic Case Management program.
Catastrophic Case Management will not only serve as an ongoing source of information about available treatments alternatives, but they can assist you in coordinating delivery of services, supplies and equipment.

The case management department is staffed by medical professionals who will answer your health care questions quickly and confidentially. To take advantage of case management, call member services at 212-255-7657 and they will direct you to a case management professional specific to your condition.

**Dietician/Nutritionist**

The Fund will allow up to 6 visits per calendar year and 18 lifetime visits for services performed by a licensed dietician.

Participating provider charges will be subject to the deductible and payable at 100% of the negotiated rate.

Non-participating provider charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule.

Any visit to a dietician will be combined with any service performed by a nutritionist not to exceed the 6 visits per year or the lifetime limit of 18 visits.

**Digital Dermoscopy Examinations for the Early Detection of Malignant Melanoma / Skin Exams – DELM:**

Annual skin exams with a dermatologist are the key to early detection of melanoma and increased survival. For high risk patients, or patients with dysplastic nevi, skin exams should be performed every 6 months. Participants should schedule a skin examination at the same time when they have their annual physical performed.

Digital Epiluminescence Microscopy (ie., digital dermoscopy) may be recommended to assist the dermatologist in monitoring you for skin cancer. Digital Epiluminescence Microscopy (DELM) uses a handheld microscope to capture and record highly magnified images of your moles. This technique allows the practitioner to view the mole beneath the surface of the skin and highlight features normally invisible. This tool is invaluable in helping the practitioner detect very early skin cancers.

Images of your moles are stored permanently and are used at subsequent visits to monitor your moles for change. Change is often the first sign of melanoma, and computerized Mole Mapping is the most accurate way of identifying change. This benefit is particularly helpful if you have many moles or have dysplastic or atypical moles.

The Fund will allow up to 2 visits per calendar year. Participating provider charges will be subject to the deductible and payable at 100% of the negotiated rate.

Non-participating provider charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule.

**Disability**

Please refer to the section of this book entitled “Weekly Loss of Time Benefit.”

**Durable Medical Equipment**

Prior approval is necessary and subject to the deductible before the Fund can make payment for this benefit.

Durable medical equipment is:
- Designed and intended for repeated use;
Primarily and customarily used to serve a medical purpose;
Generally not useful to a person in the absence of disease or injury; and
Appropriate for use in the home.

Coverage is for standard equipment only and the decision to rent or purchase such equipment will be made solely at the Fund’s discretion. Rental of the equipment will not exceed the purchase price for that piece of equipment.

Participating provider charges will be subject to the deductible and payable at 100% of the negotiated rate.

Non-participating provider charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule.

Not Covered:

- Commode, raised toilet seat and shower seat.
- Durable medical equipment that is for non-medical use (whether prescribed by a doctor or not), such as heating pads, whirlpool baths, exercise devices, ramps or handrails, air conditioners, purifiers, humidifiers or items of furniture.
- “Throwaway” medical equipment such as tubes, masks, hoses, gloves or gauzes.
- Calibration or configuration of equipment.
- Humidifiers, dehumidifiers, air purifiers or mattresses.
- Any services that are rendered prior to the Fund’s written approval for treatment.
- Payment for medical supplies furnished in or by a federal, state or local government, agency, or program or by a hospital or institution owned thereby.
- Medical supplies, including prescription drugs, considered educational, investigational, or experimental, including any treatment, drug or supply not recognized as accepted medical practice in the United States or any items requiring governmental approval not granted at the time the service is rendered.
- Medical services or supplies furnished by an individual who ordinarily resides in your home or is related to you by blood or marriage.

Durable Medical Equipment may, at the Fund’s sole discretion, be replaced if the:

- Equipment is no longer useful and has exceeded its reasonable lifetime under normal use; or
- Patient’s condition has significantly changed so as to make the original equipment inappropriate in the judgment of the Physician

Durable Medical Equipment is not replaced as a result of loss due to accident, theft, or abuse.

Durable Medical Equipment that has been purchased by the Fund cannot be given, donated or discarded without the written consent or permission of the Fund. Participants who do not get the permission of the Fund will be responsible to remunerate to the Fund the full purchase price of said equipment.

Eligibility

You are eligible for the coverage described in this manual if you are employed in a job category covered by an IUOE, Local 15, 15A, 15C & 15D Collective Bargaining Agreement, which requires that contributions be made to the Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C & 15D.

Coverage under the Plan is divided into three benefit periods of four months: January through April, May through August, and September through December.

You must submit all your fringe benefit stamps in your possession during each of the three redemption periods. The redemption periods are the months of: March through April, July through August, and November through December. Redemption will occur on any business day during these periods.
Very Important: The total hourly contribution received within a redemption period will determine your initial eligibility and continued eligibility in the Plan. Therefore, it is imperative that you:

- Review the hourly eligibility requirements carefully as they are not universal and can differ substantially by agreement or if you are an Owner Operator, and
- Redeem the benefit stamps that are in your possession during each and every redemption period.

Note: Redemption of stamps from prior periods that have an hourly rate less than the highest rate in effect at the time of redemption will be pro-rated for the hourly calculation of your eligibility requirements.

For your convenience we have categorized the eligibility rules from this point forward by Local. However, in some instances, we have further broken down the eligibility by Contractor agreement.

Attention Local 15C and 15D Participants: Some Local 15C and Local 15D members and participants work under agreements that have hourly contributions rates that are below the hourly rates being contributed by their brother or sister members. In these cases, individuals working under the following agreements will have hourly eligibility requirements that are greater than the other branches of the I.U.O.E., Local 15, 15A, 15C and 15D. If you are working under the following agreements you will need to review your eligibility requirements carefully and meet the hourly criteria in order to receive benefits under this plan.

- Local 15C - Sims/Hugo Neu Bronx Metal Recycling Agreement
- Local 15C - Small Tool Agreement – Arpielle Leasing
- Local 15C - Small Tool Agreement - Cap Rents
- Local 15C - Small Tool Agreement – Faztec
- Local 15C - Small Tool Agreement - Sunbelt Rentals
- Local 15C - Small Tool Agreement – United Rental
- Local 15D –Consultant Surveyor Agreement
- Local 15D – Nelson and Pope Agreement

Change of Eligibility Rules and Benefits

Over time, it may be necessary to change the eligibility rules and the benefits provided by the Health Benefit Fund, including benefits provided to the retirees. The Trustees, at their discretion, have the right to interpret, change, modify or discontinue all or part of the eligibility rules or benefits provided, at any time, by written amendment to this summary plan description.

Whenever policies (such as self-payment contribution rates, benefits provided, etc.) change, you will notified of the changes and copies of the changes will be on file at the Fund Office. If you have any questions about these policies, contact the Fund Office.

15 – 15A Eligibility

Initial eligibility for new members, reinstated members, transfer members and individuals working on clearance or permit working under the Local 15 – 15A Agreement.

For new members and employees joining the International Union of Operating Engineers, Local 15, 15A, and for those being reinstated from “suspension status” or “withdrawal status” there is a waiting period of six months in which you are required to perform at least 700 hours of unit work in order to be eligible for benefits outlined in this manual. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.
Continued eligibility for active members, employees and their eligible dependents

After meeting the initial eligibility requirement, you will continue to have medical coverage under the Plan for the benefit period listed below, provided you submit at least the following number of hours during each redemption period. Failure to submit your fringe benefit stamps so that they are received prior to the close of each redemption period applicable to said stamps might result in a lapse of coverage in the following benefit period.

As of September 1, 2007, the amount of hours required for continued eligibility is as follows:

<table>
<thead>
<tr>
<th>HOURS</th>
<th>BENEFIT PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>250 Hours</td>
<td>4 months of coverage</td>
</tr>
<tr>
<td>475 Hours</td>
<td>8 months of coverage</td>
</tr>
<tr>
<td>750 Hours</td>
<td>12 months of coverage</td>
</tr>
</tbody>
</table>

Credit for eligibility for overtime hours will be calculated in accordance to the rate contributed. For instance if the agreement you work under calls for a single time contribution to be made for any overtime hour worked, your eligibility for the overtime will count as one straight time hour.

15 – 15A Owner Operators

Initial eligibility for new members, reinstated members, transfer members and individuals working on clearance or permit working under the Local 15 – 15A Agreement as Owner Operators.

For Owner Operators joining the International Union of Operating Engineers, Local 15, 15A, and for those being reinstated from “suspension status” or “withdrawal status” there is a waiting period of six months in which you are required to perform at least 700 hours of unit work in order to be eligible for benefits outlined in this manual. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

Continued Eligibility: Participants that are Owner Operators, who are also members of the International Union of Operating Engineers, Local 15, 15A, are required to redeem 680 hours of stamps each redemption period to obtain the benefits available through this Welfare Fund.

<table>
<thead>
<tr>
<th>HOURS</th>
<th>BENEFIT PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>680 Hours</td>
<td>4 months of coverage</td>
</tr>
</tbody>
</table>

Overtime hours as well as straight time hours will be combined to provide credited hours for eligibility.

Failure to submit your fringe benefit stamps so that they are received prior to the close of each redemption period applicable to said stamps may result in a lapse of coverage in the following benefit period.

15-C Eligibility

Initial eligibility for new members, reinstated members, transfer members and individuals working on clearance or permit working under the Local 15C Agreement.

For new members and employees joining the International Union of Operating Engineers, Local 15C, and for those being reinstated from “suspension status” or “withdrawal status” there is a waiting period of six months in which you are required to perform at least 700 hours of unit work in order to be eligible for benefits outlined in this manual. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.
Continued eligibility for active members, employees and their eligible dependents

After meeting the initial eligibility requirement, you will continue to have medical coverage under the Plan for the benefit period listed below, provided you submit at least the following number of hours during each redemption period. Failure to submit your fringe benefit stamps so that they are received prior to the close of each redemption period applicable to said stamps might result in a lapse of coverage in the following benefit period.

As of September 1, 2007, the amount of hours required for continued eligibility is as follows:

<table>
<thead>
<tr>
<th>HOURS</th>
<th>BENEFIT PERIOD</th>
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</thead>
<tbody>
<tr>
<td>250 Hours</td>
<td>4 months of coverage</td>
</tr>
<tr>
<td>475 Hours</td>
<td>8 months of coverage</td>
</tr>
<tr>
<td>750 Hours</td>
<td>12 months of coverage</td>
</tr>
</tbody>
</table>

Credit for eligibility for overtime hours will be calculated in accordance to the rate contributed. For instance if the agreement you work under calls for a single time contribution to be made for any overtime hour worked, your eligibility for the overtime will count as one straight time hour.

15C - Owner Operators

Initial eligibility for new members, reinstated members, transfer members and individuals working on clearance or permit working under the Local 15C Agreement as Owner Operators.

For Owner Operators joining the International Union of Operating Engineers, Local 15C and for those being reinstated from “suspension status” or “withdrawal status” there is a waiting period of six months in which you are required to perform at least 700 hours of unit work in order to be eligible for benefits outlined in this manual. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

Continued Eligibility: Participants that are Owner Operators, who are also members of the International Union of Operating Engineers, Local 15C, are required to redeem 680 hours of stamps each redemption period to obtain the benefits available through this Welfare Fund.

<table>
<thead>
<tr>
<th>HOURS</th>
<th>BENEFIT PERIOD</th>
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</thead>
<tbody>
<tr>
<td>680 Hours</td>
<td>4 months of coverage</td>
</tr>
</tbody>
</table>

Overtime hours as well as straight time hours will be combined to provide credited hours for eligibility.

Failure to submit your fringe benefit stamps so that they are received prior to the close of each redemption period applicable to said stamps may result in a lapse of coverage in the following benefit period.

15-C Participants working under the Sims/ Hugo Neu, Bronx Metal Recycling Division Agreements.

For new members working under the Sims/Hugo Neu, Bronx Metal Recycling Division Agreement and for those being reinstated from “suspension status” or “withdrawal status” under this agreement, there is a waiting period of six months in which you are required to perform at least 855 hours of unit work in order to be eligible for benefits outlined in this manual. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

Continued eligibility for active members, employees and their eligible dependents

After meeting the initial eligibility requirement, you will continue to have medical coverage under the Plan for the benefit period listed below, provided you submit at least the following number of hours during each redemption period. Failure to submit your fringe benefit stamps so that they are
received prior to the close of each redemption period applicable to said stamps might result in a lapse of coverage in the following benefit period.

As of September 1, 2007, the amount of hours required for continued eligibility is as follows:

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<tr>
<th>HOURS</th>
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<tbody>
<tr>
<td>306 Hours</td>
<td>4 months of coverage</td>
</tr>
<tr>
<td>581 Hours</td>
<td>8 months of coverage</td>
</tr>
<tr>
<td>917 Hours</td>
<td>12 months of coverage</td>
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</tbody>
</table>

Credit for eligibility for overtime hours will be calculated in accordance to the rate contributed. For instance if the agreement you work under calls for a single time contribution to be made for any overtime hour worked, your eligibility for the overtime will count as one straight time hour.

**15-C Participants working under the Small Tool Agreements.**

For new members working under the Small Tool Agreements and for those being reinstated from “suspension status” or “withdrawal status” under this agreement, there is a waiting period of six months in which you are required to perform at least 733 hours of unit work in order to be eligible for benefits outlined in this manual. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

**Continued eligibility for active members, employees and their eligible dependents**

After meeting the initial eligibility requirement, you will continue to have medical coverage under the Plan for the benefit period listed below, provided you submit at least the following number of hours during each redemption period. Failure to submit your fringe benefit stamps so that they are received prior to the close of each redemption period applicable to said stamps might result in a lapse of coverage in the following benefit period.

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<tbody>
<tr>
<td>262 Hours</td>
<td>4 months of coverage</td>
</tr>
<tr>
<td>498 Hours</td>
<td>8 months of coverage</td>
</tr>
<tr>
<td>786 Hours</td>
<td>12 months of coverage</td>
</tr>
</tbody>
</table>

Credit for eligibility for overtime hours will be calculated in accordance to the rate contributed. For instance if the agreement you work under calls for a single time contribution to be made for any overtime hour worked, your eligibility for the overtime will count as one straight time hour.

**15-D Eligibility**

Initial eligibility for new members, reinstated members, transfer members and individuals working on clearance or permit working under the Local 15D Agreement.

For new members and employees joining the International Union of Operating Engineers, Local 15D, and for those being reinstated from “suspension status” or “withdrawal status”” there is a waiting period of six months in which you are required to perform at least 700 hours of unit work in order to be eligible for benefits outlined in this manual. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

**Continued eligibility for active members, employees and their eligible dependents**

After meeting the initial eligibility requirement, you will continue to have medical coverage under the Plan for the benefit period listed below, provided you submit at least the following number of hours during each redemption period. Failure to submit your fringe benefit stamps so that they are
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Credit for eligibility for overtime hours will be calculated in accordance to the rate contributed. For instance if the agreement you work under calls for a single time contribution to be made for any overtime hour worked, your eligibility for the overtime will count as one straight time hour.

15D - Owner Operators

Initial eligibility for new members, reinstated members, transfer members and individuals working on clearance or permit working under the Local 15D Agreement as Owner Operators.

For Owner Operators joining the International Union of Operating Engineers, Local 15D, and for those being reinstated from “suspension status” or “withdrawal status” there is a waiting period of six months in which you are required to perform at least 700 hours of unit work in order to be eligible for benefits outlined in this manual. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

Continued Eligibility: Participants that are Owner Operators, who are also members of the International Union of Operating Engineers, Local 15D are required to redeem 680 hours of stamps each redemption period to obtain the benefits available through this Welfare Fund.

<table>
<thead>
<tr>
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<tbody>
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<td>680 Hours</td>
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</table>

Overtime hours as well as straight time hours will be combined to provide credited hours for eligibility.

Failure to submit your fringe benefit stamps so that they are received prior to the close of each redemption period applicable to said stamps may result in a lapse of coverage in the following benefit period.

15D Participants working under the Consultant Surveyor Agreement Eligibility Requirements

For new members working under the International Union of Operating Engineers, Local 15D Consultant and Surveyor Agreement and for those being reinstated from “suspension status” or “withdrawal status” under these agreements, there is a waiting period of six months in which you are required to perform at least 885 hours of unit work in order to be eligible for benefits outlined in this manual. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

Continuation of Coverage: Once you become eligible for benefits, you will continue to have medical coverage under the Plan for the benefit period listed below, provided you submit at least the following number of hours during each redemption period. Failure to submit your fringe benefit stamps so that they are received prior to the close of each redemption period applicable to said stamps might result in a lapse of coverage in the following benefit period.
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<td>8 months of coverage</td>
</tr>
<tr>
<td>948 Hours</td>
<td>12 months of coverage</td>
</tr>
</tbody>
</table>

Credit for eligibility for overtime hours will be calculated in accordance to the rate contributed. For instance if the agreement you work under calls for a single time contribution to be made for any overtime hour worked, your eligibility for the overtime will count as one straight time hour.

For participants redeeming both Consultant Surveyor and Heavy-Local 15D stamps, be advised that the Consultant Surveyor hours will be pro-rated before they are combined and totaled for the calculation of your eligibility.

15D Participants working under the Nelson and Pope Agreement

For new members working under the International Union of Operating Engineers, Local 15D Nelson and Pope Agreement and for those being reinstated from “suspension status” or “withdrawal status” under these agreements, there is a waiting period of six months in which you are required to perform at least 987 hours of unit work in order to be eligible for benefits outlined in this manual. Once met, your benefits will begin on the first day of the first month of the following coverage period. Your initial coverage will be for one benefit period only.

Continuation of Coverage: Once you become eligible for benefits, you will continue to have medical coverage under the Plan for the benefit period listed below, provided you submit at least the following number of hours during each redemption period. Failure to submit your fringe benefit stamps so that they are received prior to the close of each redemption period applicable to said stamps might result in a lapse of coverage in the following benefit period.

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</tr>
<tr>
<td>670 Hours</td>
<td>8 months of coverage</td>
</tr>
<tr>
<td>1058 Hours</td>
<td>12 months of coverage</td>
</tr>
</tbody>
</table>

Credit for eligibility for overtime hours will be calculated in accordance to the rate contributed. For instance if the agreement you work under calls for a single time contribution to be made for any overtime hour worked, your eligibility for the overtime will count as one straight time hour.

Reciprocity - Eligibility requirements for Local 15, 15A, 15C & 15D members working outside of Local 15 jurisdiction -

Participants may not establish initial eligibility in this Fund by means of reciprocity hours. (Hours earned under another health fund with which this Plan has made arrangements for the transfer of contributions).

Only continuity of medical coverage can be provided through Reciprocity. And only Locals signatory to a Reciprocity agreement with the Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D, can reciprocate hours and contributions.

The following locals are signatory to a Reciprocity agreement with this Fund.
Local 4 (Boston, MA)
Local 14 (New York, NY)
Locals 17, 106, 410, 463, 545, and 832 (New York state)
Local 25 (Brooklyn, NY)
Local 57 (Providence, RI)
Local 66 (Pittsburgh, PA)
Local 98 (Springfield, MA)
Local 137 (Briarcliff Manor, NY)
Local 138 (Nassau & Suffolk Counties, Long Island, NY)
Local 478 (Hamden, CT)
Local 542 (Philadelphia, PA)
Local 825 (Newark, NJ and Newburgh, NY)

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<td>750 Hours</td>
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</tr>
</tbody>
</table>

Note: The Welfare Fund reserves the right to prorate hours if the out-of–jurisdiction Funds contribution rate is lower than the contribution rate currently in effect under any of the collective bargaining agreements of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D.

Participants are reminded of their obligation to contact the Fund Office immediately upon acceptance of work as an Operating Engineer outside the jurisdiction of the I.U.O.E., Local 15, 15A, 15C and 15D.

Eligibility requirements for pensioned members who elect normal retirement.
If you are receiving a regular pension from the Central Pension Plan of the International Union of Operating Engineers, you and your eligible dependents are entitled to certain Welfare Fund benefits, provided you are over the age of 62 and meet one of the following criteria:

- You have 25 years of pension credits at the time you apply for retirement; or
- You have at least 10 years of vested pension credits and have accumulated at least three of those years of pension credits during the five successive years immediately prior to your date of retirement.

The benefits you and your eligible dependents are entitled to receive can be found in the section of the book entitled “Benefits and Provisions for eligible Pensioned Members who are 62 and older and not entitled to receive Medicare Benefits” or “Benefits and Provisions for Pension Members and their Eligible Dependents who are eligible for Medicare”

Note: Retirement is an excellent opportunity to update both your enrollment and beneficiary information as well as complete a new authorized representative form and health care proxy.

Eligibility requirements for members who elect early retirement.
If you elect for early retirement your coverage will cease with this Plan upon the normal cessation of the benefit period you are covered through at the time of early retirement approval from the Central Pension Fund.

However, provided that you meet the following requirements:
1. You had twenty-five years or more of vested pension credits; and
2. You were covered for medical benefits by this Fund at the time you were approved for an early retirement pension by the Central Pension Fund, and
3. You are 65 years or older, and Medicare eligible.
You would be reinstated into the plan and entitled to receive the benefits that are outlined in the section of the book entitled “Benefits and Provisions for Pension Members and their Eligible Dependents who are Eligible for Medicare Benefits”.

Provided your spouse meets the following criteria:

1. Attains the age of 65 or older, and
2. Is Medicare eligible.

He/she would be reinstated into the plan and entitled to receive the benefits that are outlined in the section of the book entitled “Benefits and Provisions for Pension Members and their Eligible Dependents who are Eligible for Medicare Benefits”.

Dependent children, regardless of age will not be reinstated into the plan.

Note: If you are electing this provision, please make sure that you update both your enrollment and beneficiary information as well as complete a new authorized representative form and health care proxy.

Eligibility requirements for members who are awarded a Social Security Disability.

If you are awarded Social Security disability benefit while you are a covered member, you and your eligible dependents are entitled to certain Welfare benefits provided you meet the following criteria:

1. You have 15 years of contributions of at least 1000 hours per year into the Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D.
2. You were covered under this plan at the time you were awarded a Social Security disability, and
3. You were covered under this plan during each benefit period in three of the five successive years immediately prior to the onset date of your disability, and
4. The Central Pension Fund of the International Union of Operating Engineers, in connection with such permanent and total disability, awarded you a disability pension while you were covered under this plan.

Participants wanting to avail themselves of this benefit must submit a copy of their Social Security Disability award to the Plan Administrator. The award must state that the onset of your disability occurred prior to your original termination with the Plan.

The benefits you will be entitled to receive are those that are outlined in the section of the book entitled “Benefits and Provisions for Pension Members and their Eligible Dependents who are not eligible for Medicare Benefits”. The Fund will provide these benefits until such time that you or your eligible dependents become Medicare or Medicaid eligible. At that time the benefits you will be eligible to receive will be those that are outlined in the section of this book titled “Benefits and Provisions for Pension Members and their Eligible Dependents who are eligible for Medicare Benefits”.

Note: If you are electing this provision, please make sure that you update both your enrollment and beneficiary information, as well as complete a new authorized representative form and health care proxy.

Eligibility for members entitled to Medicare Benefits who cease to actively work.

For Medicare eligible members who have earned enough hours to meet the eligibility requirements for an active member but cease to be actively employed by a contributing employer within the jurisdiction of the I.U.O.E., Local 15, 15A, 15C & 15D, Medicare will be considered your primary insurer and the Welfare Fund your secondary insurer on the date you cease to be actively employed.
Important:

1. Participants must notify the Fund of the date that they ceased to be actively employed in writing no later than two weeks after said date, so that the Fund may properly coordinate your benefits with those of Medicare.

2. Participants are reminded that they need to sign up for Medicare Benefits at the earliest time they are eligible in order to maximize the benefits contained within the section of the Book titled “Benefits and Provisions for Pensioned Members and their Eligible Dependents, Who are Entitled to Medicare.”

   Please note that the use of the word “entitled” is deliberate as the benefits of a non-actively contributing participant age 65 or older will only be entitled to the benefits outlined within the aforementioned section.

3. Participants that fail to notify the Fund Office or those who knowingly file their claims to the incorrect insurer will be subjected to the Fraud provisions of the Welfare Fund.

4. Participants who are entitled to receive Medicare Benefits are directed to read the provisions (outlined below) contained within the gold section of this booklet titled “Benefits and Provisions for Pensioned Members and their Eligible Dependents, Who are Entitled to Medicare.”

   ➢ Coordination of Benefits, and
   ➢ Eligibility, and
   ➢ Enrollment, and
   ➢ Medicare

Note: The rules and plan design of the aforementioned provisions will be strictly adhered to.

Eligibility for weekly loss of time benefit.

Every participant is eligible to receive weekly loss of time benefits immediately upon employment with a contributing employer for a maximum of 26 weeks provided they performed unit work under the jurisdiction of Local 15 and provided they are not receiving unemployment or workers compensation benefits at the same time. Please refer to the section of this manual entitled “Weekly Loss of Time Benefits.”

Eligibility for continued coverage for the eligible dependents of an “Active” deceased member.

As long as the participant had coverage at the time of death, coverage for Welfare Fund benefits will be extended to the surviving spouse, handicapped children and unmarried eligible dependents under the age of 24 for a period of 36 months from the date of death of the participant.

Coverage will be determined in the following manner:

- Benefits for spouses who have not attained the normal retirement age of 62 will be paid according to the provisions found in the section of this manual entitled “Benefits and Provisions for Active Working Members and their Eligible Dependents.”

- Benefits for surviving spouses who have attained the age of 62 will be paid according to the provisions found in the section of this manual entitled “Benefits and Provisions for Retired Participants and their Eligible Dependents who are not eligible for Medicare Benefits.”
• Benefits for surviving spouses age 65 or older who are eligible for Medicare will be paid according to the provisions found in the section of this manual entitled “Benefits and Provisions for Pensioned Members and their Eligible Dependents Who are Eligible for Medicare Benefits.” Your coverage under the Plan will be coordinated with Medicare regardless of whether you enrolled in Medicare.

Coverage for any unmarried eligible dependent child of a member who at the time of death had medical benefits will be determined in the following manner:

• Benefits for the unmarried dependent of Active participants who have not attained their 19th birthday will be paid according to the provisions found in the section of this manual titled “Benefits and Provisions for Working Members and their Eligible Dependents.”

Benefits will only be paid for a maximum of 36 months, or until the dependent’s 19th birthday, whichever comes first. Benefits beyond the 19th birthday but less than the maximum 36-month period will be granted provided that the child, upon attaining his or her 19th birthday, enrolls or is enrolled in an accredited school as a full-time student. Coverage will cease upon failure to maintain status as a full-time student during the remainder of the 36-month period.

• Benefits for an unmarried dependent child older than 19 who is attending an accredited school as a full-time student at the time of death will be covered for 36 months up to either his or her graduation, 24th birthday or upon the failure to maintain status as a full-time student during that period, whichever comes first.

Note: If you are receiving Health and Welfare benefits as a result of the death of an active member, you are urged to read the benefit section entitled “House Calls”.

A loss of a love one affects the entire family. Due to grief, there are often causes and effects that go unnoticed until months later.

The Trustees who oversee the Fund Plan understand this and have created the House Call benefit in response.

What is House Call? It is a “check in” service where we may come to you to make sure that you and your family are aware of all services provided by the Welfare Fund to help you through this trying time.

Additionally, survivor participants are encouraged to call the Fund Office if they need assistance updating their authorized representative form, enrollment form, health care proxy and beneficiary forms.

Eligibility for continued coverage for the eligible dependents of a “Retired” deceased member.

As long as the participant had coverage at the time of death, coverage for Welfare Fund benefits will be extended to the surviving spouse, handicapped children and unmarried eligible dependents under the age of 19 for a period of 36 months from the date of death of the participant.

Coverage will be determined in the following manner for any unmarried eligible dependent child of a member who at the time of death had retired benefits without Medicare benefits or retired benefits with Medicare benefits:

➢ Upon attaining the age of 65 or becoming Medicare eligible, whichever is first, the benefits for the surviving spouse will be those that can be found in the section of this book titled “Benefits and Provisions for Pension Members and their Eligible Dependents who are eligible for Medicare Benefits”.

➢ Benefits for unmarried dependents of Retired participants that have not attained the
dependent’s 19th birthday will be paid according to the provisions found in the section of this manual titled “Benefits and Provisions for Pension Members and their Eligible Dependents who are not eligible for Medicare Benefits.”

Benefits will only be paid for a maximum of 36 months, or until the dependent’s 19th birthday, whichever comes first. Benefits beyond his or her 19th birthday will not be paid.

Note: If you are receiving Health and Welfare benefits as a result of the death of a retired member, you are urged to read the benefit section entitled “House Calls”.

A loss of a love one affects the entire family. Due to grief, there are often causes and effects that go unnoticed until months later.

The Trustees who oversee the Fund Plan understand this and have created the House Call benefit in response.

What is House Call? It is a “check in” service where we may come to you to make sure that you and your family are aware of all services provided by the Welfare Fund to help you through this trying time.

Additionally, if you as the survivor participant need assistance updating your enrollment form, authorized representative form, health care proxy form or beneficiary form, you are encouraged to call the Fund Office.

Getting Married

When you get married, your spouse is automatically eligible for coverage effective as of the date of your marriage. However, no benefits will be processed by the Fund Office until you have provided to the Fund Office a completed enrollment form along with any required supportive documentation or information outlined in the section of this book titled Enrollment.

Please notify the Fund Office as early as possible after your marriage. However, if you do not notify the Fund Office within 30 days of your marriage date, your spouse’s coverage will not begin until the first day of the month after you notify the Fund Office.

Participants who are either getting married or have recently married may wish to update their beneficiary designation under the Plan, as well as complete an authorized representative form and health care proxy. Please contact the Fund Office to request a beneficiary form or login at benefitfunds.iuoe15.org to download a form.

Getting Divorced

If you and your spouse get divorced, your spouse will no longer be eligible for coverage as a dependent under this Plan effective as of the date the divorce is final. However, your spouse may elect to continue coverage under C.O.B.R.A., for up to 36 months. You or your spouse must notify the Fund Office within 60 days of the divorce date for your spouse to obtain C.O.B.R.A., continuation coverage.

In general, once you are divorced, stepchildren from your former marriage are no longer covered under the Plan, but may be eligible for C.O.B.R.A., continuation coverage.

The Fund Office requires you to submit supporting documentation such as a copy of your divorce decree or a copy of any Qualified Domestic relations Order (QDRO) and/or Qualified Medical Child Support Order (QMCSO).

Losing Eligibility

The Welfare Fund is designed to provide benefits for all eligible Participants and their eligible
dependents. However, it is possible for you and/or your dependents to lose eligibility for coverage.

You and/or your eligible dependents may lose eligibility if:

1. You fail to submit the required amount of hours during a redemption period.
2. You do not make the required self-payment contributions on time as explained in the C.O.B.R.A., section of this summary plan description.
3. You or your dependent’s commit a fraudulent act against the Fund.
4. You are inducted into the Armed Forces (see Uniformed Services Employment and Reemployment Rights act of 1994)
5. In the event of a divorce, your spouse and stepchildren’s eligibility ends on the date a divorce is final. Your spouse and stepchildren may be eligible to continue coverage by electing COBRA continuation of coverage.
6. There is a written amendment to this summary plan description that affects eligibility.

Enrollment

In order for your dependents to be covered under the Plan, they must be enrolled.

To be enrolled you must completely fill out an enrollment form. The information you supply on this form is needed by the Fund Office to provide benefits to you and any eligible dependents. No benefits will be processed by the Fund Office without this information.

Certain dependents such as step-children, adopted children, students and parents require continuous information to be submitted to the Fund Office in order to maintain their eligibility by confirming dependent status. A “dependent” is defined as:

- Your lawful spouse;
- Your unmarried natural or legally adopted child under the age of 19 who resides with you in a normal parent–child relationship;
- Your unmarried stepchild under the age of 19 who resides with you in a normal parent–child relationship (provided the criteria for step-children is met and documentation such as birth certificates, letters of other insurance, annual federal income tax return proving support by member.)
- An active member’s natural child, legally adopted child under the age of 24, who has never been married, who is registered as a full–time student at an accredited school and is dependent upon you for support. Benefits will terminate on the date of graduation or at age 24, whichever comes first.
- Your natural child, or legally adopted child, age 19 or older who has never been married and is totally disabled and therefore cannot earn a living, as long as the child is dependent on you for support.
- Your mother and/or father as long as you are an active member, not married or never divorced; and you provide more than half the financial support for your mother and/or father; and you declare your mother and/or father as dependents on your federal income tax return in the year preceding the date of the service for which you are claiming benefits.
- Handicap children under the age of 19.
Handicap children over the age of 19: Extended coverage is available for an unmarried child who is over age 19, cannot work and depends on you solely for support because of mental, developmental or physical disability or illness and became so disabled before reaching age 19. You must provide proof to the Fund Office that your child’s disability began before the child reached age 19 and you must do so no later than 31 days after the child’s 19th birthday. For all handicapped children, the Fund Office periodically requires substantiation of the child’s continued handicap, which may include a physical examination. Without this proof, coverage may be terminated.

Any person who does not meet any of the aforementioned definitions will not be considered eligible under this plan.

Proof of dependent status is necessary in order to establish eligibility. Consequently, the Fund will require you to provide certain written forms of proof. These include, but are not limited to the following items:

- Marriage (marriage certificate)
- Newborn (birth certificate, which must be received within 30 days of the child’s birth)
- Adoption (legal adoption papers or other documentation that may be requested by the Fund Office)
- Financial support and/or parental coverage for parents (to confirm eligibility status for a dependent mother or father, a participant must provide to the Fund for inspection a copy of his or her parent’s marriage certificate, and birth certificates. In addition, each year the member must submit a copy of the section of his or her tax return that confirms that his or her mother or father is listed as a dependent. Your tax return should be submitted no later than May 1 of the calendar year in which it is due).
- Handicapped Children: The Fund reserves the right at any time to request a copy of the section of the member’s tax return that confirms dependent status for a handicap child or to request additional documentation such as a physical exam to substantiate the child’s continued handicap.
- Stepchildren: The Fund will require a copy of the following in order to establish the initial eligibility of the stepchildren under your policy
  1. A copy of the step-child’s birth certificate
  2. A copy of the natural parent’s judgment of divorce and stipulation of settlement. (Needed because the Court often dictates within these documents the natural parents responsibility as it pertains to insurance coverage)
  3. In the case where the natural parent is a widower, a photocopy of that individual’s late spouse’s death certificate will be required.

On going eligibility for your stepchild will require annual verification of your financial support for the stepchild. Consequently, each year the member must submit a copy of the section of his or her tax return that confirms dependent status for the stepchild or stepchildren. The tax return must be received by the Fund no later than May 1, of the calendar year in which it is due.

In addition, if your stepchild is over the age of 19, their on-going eligibility will also be determined upon whether or not they are a full time student in an accredited institution. Please refer to the criteria outlined within the next bullet point titled “Student status”.

- Student status: The Welfare Fund requires a copy of the dependent student’s certification form, or a registrar’s report or a bursar’s letter attesting to the child as a full-time student (12 or more credits) at the accredited institution. Verification for the fall semester must be received.
no later than September 30. Verification for the spring semester must be received no later than January 31.

- Qualified Medical Child support Order (QMCSO). The Plan also covers children as required by a valid Qualified Medical Support Order (QMCSO) issued by a court. The Fund Office will review the order to see if it meets legal requirements.
- Residence (utility bills or any other requested documentation).
- Social Security numbers (copies of the participant’s and dependent’s Social Security cards).

Missing, incomplete or the untimely submission of any of the aforementioned documents will result in your dependents being unable to claim benefits from this Plan. Consequently, it is of the utmost importance to your family that you spend a few minutes making sure that every section of the enrollment form is complete and that you have provided the Fund with the supporting documentation.

All eligible dependents will be enrolled in the Plan on the first day of the following month from the date the Fund Office receives and deems complete all supporting documentation. Any bills incurred prior to that time will remain your responsibility.

In addition to providing the above information, you and/or your covered dependents must immediately furnish in writing any information that may affect your eligibility for coverage or the Fund Office’s ability to properly administer your benefits. Such items include, but are not limited to:

- Change of name.
- Change of address.
- Addition of dependents by birth or adoption.
- The marriage, divorce or death of you, any covered spouse or dependent child.
- Information regarding the status of a dependent child, including but not limited to:
  1. The child reaching the Plan’s limiting age;
  2. The school status of a dependent child over the age of 19, who has never been married; or
  3. The existence of a physical or mental handicap for a child prior to his or her 19th birthday.
- The marriage of your dependent child.
- Medicare or Medicaid enrollment or un-enrollment.
- Social Security disability benefits award or notice of termination.
- The existence of other medical, dental, prescription or optical coverage (you are required to disclose the fact that you or any of your dependents are covered by more than one insurance plan).
- The fact that you were placed on family medical leave with your employer.

Your failure to provide any of this information in writing could result in you or your dependents’ inability to claim benefits from this Fund or the termination of coverage.

The Fund has the right to require any of the aforementioned documents from time to time and as often as it determines reasonably necessary, as proof for enrollment and eligibility purposes.

All enrollment documents must be mailed by certified / return receipt mail to the Welfare Fund Office at the following address:

The Welfare Fund of the International Union of Operating Engineers
Local 15, 15A, 15C and 15D
Attn: Enrollment Department
265 West 14th Street, Room 500
New York, NY 10011
Covered members and their families are required to notify the Fund Office about a divorce, legal separation, other insurance coverage, or a child losing dependent status under the Plan. Such notification must take place immediately after any of these events occurs. If such an event is not reported to the Fund Office within 60 days after it occurs, coverage will not be provided to the dependent.

Coverage for you and your dependents may terminate at any time if there is a misrepresentation on any of the enrollment forms or if you allow a fraudulent claim to be filed. Reinstatement, if any, will be at the sole discretion of the Board of Trustees.

Once again, if any of the above mentioned documentation is missing, or is incomplete, the Fund will be unable to provide medical benefits to you or your dependents.

As previously stated, all eligible dependents will be enrolled in the Plan on the first day of the following month from the date the Fund Office receives and deems complete all supporting documentation. Any bills incurred prior to that time will remain your responsibility.

Parents of newborn children will be given a grace period of three months from the date of their child’s birth to submit the proper documentation. Claims incurred after that time will remain the responsibility of the member.

Facsimile (faxed) copies of enrollment forms and supportive documentation will not be accepted.

Important Notice: The Plan is subject to federal laws, which provide that criminal penalties may be imposed against those who receive or attempt to receive health care plan benefits by committing fraud or abuse against the Plan. State fraud and abuse laws may also apply. For more information, please reference the section of this book entitled “Fraud & Abuse.”

**Emergency Room Care**

Emergency room care is described as:
- An accidental injury;
- Services rendered within 72 hours following such injury;
- The onset of sudden or serious illness;
- Services rendered within 12 hours of the onset of serious or sudden illness;

Emergency room expenses for a legitimate emergency are not subject to the deductible.

Emergency room facility charges for legitimate emergencies will not accumulate to the participant’s lifetime major medical allowance. However, the doctor’s charges will accumulate toward the major medical maximum.

Participating network facilities and non-participating facilities are paid at 100% of the negotiated rate for legitimate emergencies only.

The Fund reserves the right to review all appropriate medical records and make the final decision regarding the existence of a medical emergency. Regarding such retrospective reviews, the Fund will cover only those services and supplies that are medically necessary and are performed to treat or stabilize a medical emergency.

The Fund will not cover emergency room care if:
- You use the services of the emergency room staff because you do not have a regular doctor.
- Your need for treatment is not sudden and serious, or it is late at night or on a weekend and you choose not to call your doctor, or your doctor is available or unavailable.
- Care is for a follow-up visit.
Facility and professional charges for services other than a true emergency will be subject to the participant’s annual deductible and will be paid at 80% of the Fund’s usual, customary and reasonable fee schedule, and will accumulate toward the participant’s lifetime major medical allowance. Any remaining balance for these services will remain the responsibility of the participant.

Diagnostic testing performed in a hospital including the emergency room of a hospital (if not a true emergency) will be subject to the deductible and paid at 80% of the Fund’s usual, customary and reasonable fee schedule whether the hospital is participating or not participating.

Epidural Steroid Injections/Nerve Blockers

Prior approval is required. The Fund allows up to three epidural/nerve blocker steroid injections per calendar year.

Epidural/Nerve blocker steroid injections when performed by a participating network provider will be subject to the deductible and paid according to the negotiated rate for the provider.

Epidural Steroid Injections when performed by a non-participating provider will be subject to the deductible and paid at 80% of the usual, customary and reasonable fee scheduled for the services of the provider.

Epidural/Nerve blocker steroid injections when performed in a participating network facility will be paid at 100% of the negotiated facility fee rate.

No allowance will be paid toward a non-par facility fee.

Exclusions, Exceptions and Plan Limitations

No payments will be made for:

- Alcohol and substance abuse treatments without prior authorization.
- Any injury or illness or services and supplies that arise out of or in the course of employment that are compensable under workers’ compensation, occupational disease, or similar laws, whether or not the right under the law is asserted (except as provided for as a non-medical benefit under the Plan).
- An injury or illness resulting from or occurring during an attempt to commit or commission of a misdemeanor or felony or participation in a public disturbance or riot.
- An injury or illness resulting from past or present military service or caused by or arising from an act of war, whether declared or not, or a conflict involving armed forces.
- An intentionally self-inflicted injury or illness.
- Anesthesia services that were administered by the operating surgeon, his or her assistant or an employee of a hospital or similar institution or a Certified Registered Nurse Anestesiologist (CRNA).
- Any balance or fee for services and goods not covered by the Plan.
- Any balance remaining after the Fund’s payment for services performed by non-participating providers.
- Any charges to the extent that they are considered unreasonable by the Welfare Fund.
- Any expense, charge or fee incurred for missed appointments.
- Any expense or charge for the treatment of craniomandibular or temporomandibular joint (TMJ) disorders unless proven to be medically necessary.
- Any expense that is in excess of the Fund’s reasonable and customary charge.
- Any expense or charge for services or supplies not medically necessary or not recommended by a doctor.
- Any expense incurred after coverage ends.
- Any expense or charge for which the covered person does not have to pay. For example, when a provider of care does not usually collect charges in the absence of insurance coverage, no benefits are provided. This exclusion applies even if charges are billed.
- Any expenses or charges for services or supplies which are chiefly for instruction, education or training.
- Any expense, fee or charge associated with non-network affiliated surgical centers.
- Any expense of charge associated with adoption or surrogate parentage.
- Any expense for the creation, collection or copying of medical records or fees to complete medical forms.
- Any expense associated with the diagnosis and treatment infertility above the allowance set forth within this book.
- Any loss, expense or portion thereof, for which mandatory automobile no-fault benefits are recovered or recoverable.
- Any loss, expense or charge that results from cosmetic surgery.
- Any loss, expense or charge that results from reconstructive surgery, except for injuries received while covered under the Plan, or repair of congenital defects of newborn children.
- Any service rendered by practitioners beyond the scope of their licenses.
- Assistant surgeon fees, except for procedures when this assistance is necessary for the successful outcome of the surgical procedure and not to exceed 25% of the allowable expense of the surgical procedure.
- Behavioral counseling or treatments.
- Biofeedback counseling, treatments or testing.
- Birthing center charges at non-participating facilities.
- Blood handling.
- Children who are not legal dependents of the member.
- Services performed by a Certified Registered Nurse Anesthesiologist (CRNA).
- Chelating therapy for members, spouses and dependents except for acute arsenic, gold, mercury, and lead poisoning or for other foreign substances induced while performing the daily duties or function of an operating engineer.
- Commode, raised toilet seat and shower seat.
- Common law or life-partners are not covered.
- Cosmetic surgery.
- Dental fluoride treatments.
- Dental Implants.
- Dental Sealants.
- Doctor charges from non-network providers that are in excess of the Fund’s reasonable and customary fee schedule.
- Durable medical equipment without prior authorization.
• Durable medical equipment which is for non-medical use (whether prescribed by a doctor or not), such as heating pads, whirlpool baths, exercise devices, ramps or handrails, air conditioners, purifiers, humidifiers or items of furniture.

• Durable medical equipment that can be considered “throwaway,” such as tubes, hoses, gloves or gauzes.

• Epidural Injections without prior approval.

• Expenses for inpatient and outpatient substance abuse for treatment not approved or coordinated by the Fund.

• Exogenous obesity, or weight reduction and control expenses or charges that result from appetite control or any treatment of obesity (except for surgery to treat morbid obesity, which is defined as an adult who has been more than 100 pounds over normal weight for at least five years and is corroborated with medical reports).

• Facility charges from non-licensed facilities.

• Foster children, grandchildren or siblings, unless adopted by the member, are not covered.

• Fitting, repairing or replacement batteries for hearing aids.

• Genetic counseling.

• Home Care without prior approval.

• Hormone Therapy or treatments.

• Hospital limitations:
  1. Hospital outpatient testing: All outpatient diagnostic testing performed in an in-network hospital or an out-of-network hospital will be paid at 80% of the Fund’s usual, customary and reasonable fee schedule. Any remaining balance, deductible or co-insurance will remain the responsibility of the patient.
  2. Hospitalizations for dental care, unless prior approval is obtained and/or is certified by your physician as necessary to protect your life or health.
  3. Separate charges by a salaried hospital physician.
  4. Take-home drugs.
  5. Inpatient treatment of a mental or nervous disorder, except as stated in the pages of this manual entitled “Inpatient Mental Health Benefits.”
  7. Confinements, services, fees for nursing homes, rest homes, facilities for the aged, facilities not related to skilled nursing care, physical restoration or spas; or for any confinement in any facility not related to injury or surgery requiring prior hospitalization.
  8. Surgical procedures commonly performed in a physician’s office, such as proctosigmoidoscopy, vasectomy, etc.

• Injuries and diseases covered under any workers’ compensation programs.

• Lapband adjustments one year or more after the surgery.

• Lasik Surgery without prior approval.

• Learning disabilities, delayed speech development, mental retardation, developmental delay, behavioral problems, or special education.
• Lifts for wheelchairs, including lifts for staircases.
• Marriage counseling.
• Certain benefits associated with maternity:
  1. Any maternity services that are a direct result of copulation or conception by anyone other than a married member and the legal spouse.
  2. The Welfare Fund will pay for three sonograms. Any sonogram beyond the three will not be paid for unless the Fund Office receives a letter of medical necessity and approves the additional sonograms prior to the service being rendered. The Fund must receive the letter of medical necessity, or grant its approval prior to the service date. Sex, size, weight of the fetus, or timing of delivery are not considered medical necessities.
  3. Services of a midwife will be paid up to the amount that does not exceed the amount that would be payable under the Plan if the services were performed by a physician.
• Maternity services and supplies provided by a hospital or birthing center that includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.
• Medical services or supplies furnished in or by a federal, state or local government, agency or program or by a hospital or institution owned thereby unless required by law.
• Medical services or supplies, including prescription drugs that are considered educational, investigational or experimental, including any treatment, drug or supply not recognized as accepted medical practice in the United States or any items requiring governmental approval not granted at the time service is rendered.
• Medical services or supplies furnished by an individual who ordinarily resides in your home or is related to you by blood or marriage.
• Nebulizer supplies (ie tubes, masks, disposable supplies).
• Nutritionist services performed by nutritionists who do not hold a master of science (MS) from an accredited university.
• Nurse Practitioners.
• Occupational therapy without prior approval.
• Oocyte cryopreservation.
• Orthotic casting, fitting or molding.
• Orthotics without prior approval.
• Orthotripsy without prior approval.
• Osteopathic Manipulation with a D.O. or M.D. is not covered.
• Pain management or palliative treatments.
• Panniculectomy.
• Physical therapy without prior authorization.
• Physical therapy by a podiatrist and/or chiropractor.
• Physician Assistants.
• Podiatry care for surgical procedures (unless such treatment is rendered at the written request of a legally qualified orthopedist).
• Psychological treatments without prior authorization.
• Refraction is not covered.
• Relationship counseling.
• Services relating to or resulting from the participant’s decision for gastric bypass or bariatric surgery, including but not limited to mental health treatments and reversal of the surgery are not covered.
• Sonograms only to determine size of the fetus or timing of delivery are not covered.
• Speech therapy without prior approval.
• Speech therapy for developmental delay.
• Strapping included in the office visit fees.
• Supplies, drugs, treatments or therapy not approved by the FDA.
• Surgical Trays.
• Telephone Consultations.
• Therapy services, such as recreational, educational, music or art therapies, or physical fitness or exercise programs.
• Third party liability claims, except as provided for under the Plan.
• Transsexual surgery.
• Vitamins, including over-the-counter vitamins.

Experimental or Investigative Procedures and Services

Experimental or Investigative procedures and services are not covered under this Plan. In order to determine whether or not the procedure or service is experimental or investigative the Fund shall use the following definition:

Experimental or Investigative is the use of any treatment, service or supply for a participant’s illness or injury that at the time it is used:

• Requires approval by the appropriate Federal or other government agency that has not been granted, such as, but not limited to, the Food and Drug Administration (FDA);
• Is not yet recognized as acceptable medical practice throughout the United States to treat that illness or injury;
• Is the subject of either:
  ➢ A written investigational or research protocol;
  ➢ A written informed consent of protocol used by the treating facility in which reference is made to it being Experimental, Investigative, educational, for a research study, posing an uncertain outcome, or having an unusual risk;
  ➢ An ongoing phase I, II or III clinical trial; or
  ➢ An ongoing review by an Institutional Review Board (IRB); or

Does not have either:

➢ The positive endorsement of national medical bodies or panels, such as the American Cancer Society; or
➢ Multiple published peer review medical literature articles, such as the Journal of the American Medical Association (J.A.M.A), concerning such treatment, service, or supply, and reflecting its recognition and reproducibility by non-affiliated sources determined to be authoritative by the Fund.
Family and Medical Leave

You may be entitled by law to up to 12 weeks of unpaid leave under the Family and Medical Leave Act (FMLA), which is for specified family or medical purposes, such as the birth or adoption of a child, to provide care of a spouse, child or parent who is seriously ill, or for your own serious illness. You can keep your medical coverage in effect during that period. If your employer does not make contributions for coverage during FMLA leave, the Fund will not absorb the cost of the coverage during such leave. If you do not return to work after your FMLA leave ends, you may be required to repay the amount your employer paid toward your coverage.

If you do not return to covered employment after your leave ends, you are entitled to continue your coverage under the COBRA provision described in the section of this manual entitled “COBRA.”

You are required to notify the Welfare Fund Office that you have chosen to participate in the company’s family medical leave program or that you were placed in the company’s family medical leave program.

Questions regarding your entitlement to FMLA should be referred to your employer and your employer’s Family Medical Leave Policy information notice.

Fraud & Abuse

Criminal penalties may be imposed against those who receive or attempt to receive health care plan benefits by committing fraud or abuse against the Plan. State fraud and abuse laws may also apply.

Any person who commits a fraudulent act against the Plan may be subject to a possible loss of benefits, as well as criminal prosecution, fine or imprisonment as provided by law. The following items listed may be considered fraud or abuse against the Plan:

1. Falsifying, withholding, omitting or concealing information to obtain coverage.

2. Misrepresenting eligibility criteria for dependents (for example, marital status, age, full-time student status, dependent child or the right to claim a dependent for federal income tax purposes) to obtain or continue coverage for a person who would not otherwise meet the dependent eligibility criteria, as defined in the Plan, and qualify for coverage.

3. Withholding, omitting, concealing or failing to disclose any medical history or health status where the person is required to calculate benefit payments or determine pre-existing conditions for which there is no creditable coverage.

4. Making or using any false writing or document in connection with obtaining coverage or payment for health benefits, including falsifying or altering (a) a certificate of creditable coverage to reduce or eliminate waiting periods or pre-existing conditions or limitations under the Plan, (b) a claim form, or (c) medical records.

5. Permitting a person who is not covered under the Plan to use a plan identifying information to obtain covered services or payment under the Plan.

6. Making false or fraudulent representations in connection with delivery of or payment for health benefits, or being untruthful to obtain reimbursement under the Plan.

7. Obtaining, or attempting to obtain, medical care or covered services under the Plan by false or fraudulent pretenses.
Gastric Bypass

Prior approval is required before the Fund can make payment toward this benefit. The Fund will allow up to a maximum global surgical allowance of $4,000.00 for Gastric Bypass Surgery provided the procedure is used solely to treat morbid obesity. The Fund will not make any payment for this benefit unless a true life-threatening medical condition exists. Failed diets or lack of eating discipline and/or exercise programs do not constitute a life-threatening medical condition.

Participants must meet the following criteria in order to be eligible for this benefit:

- At least 100 pounds over normal weight for more than five years; and

- Six (6) continuous months of non-surgical methods of weight reduction supervised, monitored and documented by a medical physician or health professional during the past 2 years

A letter of medical necessity along with the patients complete medical report, medical diagnosis and supporting documentation is required in order to obtain prior approval and to determine that surgery is not being performed for any cosmetic reason.

Participating provider charges will be subject to the deductible and payable at the negotiated rate up to the global surgical allowance of $4,000.00.

Non-participating provider’s charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable global fee schedule of $4,000.00.

Future “Band Adjustments” are covered only up to the first year following the surgery and requires prior approval.

Panniculectomy or re-contouring to remove loose skin, as a result of bariatric, or stomach stapling surgery, will not be paid for by the Fund. This includes, but is not limited to, tummy tuck, belt lipectomy, brachioplasty, breast lift/reduction, and thighplasty.

Additionally, the Fund will not pay for any condition or illness resulting from the participant’s decision to have Gastric Bypass, including, but not limited to, the reversal of the Gastric Bypass Surgery or psychological treatments.

The Fund reserves the right to require a second opinion for any surgical procedure or disability.

Genetic Testing

The Fund provides benefits for the services associated with Genetic Testing. Services include, but are not limited to, X-ray, examinations, imaging services such as MRI’s and Cat Scans, radiology imaging, mammographies, laboratory services and other genetic testing services.

Genetic Testing performed in a participating facility other than a hospital, will be subject to the deductible and paid at 100% of the negotiated rate.

All genetic testing performed either in a participating or non-participating hospital or facility will be subject to the deductible and paid at 80% of the Fund’s usual, customary and reasonable fee schedule.

Genetic counseling is not covered.

Hearing Aid Benefits

Regrettably, loss of hearing is one of the hazards of working within our industry. Few members are aware that hearing loss is generally compensable under your employer’s workers’ compensation policy. Provided you can establish proof that your hearing loss was work related, you may be entitled
to receive a monthly stipend from the employer’s workers’ compensation insurance company for the rest of your life.

In order to establish proof, each member should have his or her hearing checked during his or her annual physical. Doing so establishes a “baseline” to which future tests can be compared, and will establish proof in order to receive a monthly compensation stipend from your workers’ compensation insurance company.

If your employer’s workers’ compensation insurance company is contesting your hearing loss claim, you may obtain a hearing aid through this Fund and subject to its subrogation provision up to the limits set forth directly below.

The Fund will allow $850 per ear, per participant, once every five calendar years for non-work related hearing loss. Fitting, Repair, and replacement batteries for hearing aids are not covered.

While you may go to any hearing center you like, the Plan has established a relationship with General Hearing Services. As such, the Fund has been able to enhance the aforementioned benefits in a manner that can reduce your out-of-pocket cost. For a listing of the provider locations, please call the Fund Office or go online to benefitfunds.iuoe15.org.

**HIPAA Release Form**

If you are a caregiver, ask your spouse, dependent child of legal age (18 or older) or even parent, to sign a HIPAA release form. This form allows the Fund personnel to speak with you about that individual’s bills and payments. Without a completed signed authorization on file, the Fund will not be able to speak to you about another individual’s medical claims.

To obtain a copy of this form please contact member services at 212-255-7657 or go online to benefitfunds.iuoe15.org.

**Home Health Care**

Prior approval is necessary before the Fund can make payment for this benefit.

The maximum of allowable home care visits per lifetime is 200 visits. The Fund will provide home health care when this care is given after a hospitalization and provided care begins within 7 days after discharge with a participating state certified home care agency.

Home care benefits are available under a physician-approved plan of treatment when the necessary services are rendered through a network participating, state-certified home health agency. Benefits will be provided only if the patient is homebound and hospitalization or confinement in a skilled nursing facility would otherwise have been required.

Covered services include: Part-time professional nursing; part-time home health aide services (up to a TOTAL of four hours of such care is equal to one home care visit); physical, occupational, or speech therapy; medical supplies, drugs and medicines prescribed by a physician; and necessary laboratory services.

Under this benefit the deductible does not apply and fees do not accumulate towards the participant’s lifetime major medical allowance.

If you:

1. Have not been released from an inpatient hospitalization of three or more days, and/or
2. Failed to elect to utilize this benefit within seven days of discharge;
3. Elected the services of a non-par and/or non-state certified home health care agency; or
4. Have been prescribed home care services but fail to meet the above requirements,
Please reference the section of this book titled "Supplemental Medical Health Benefits".

**Hospice Care**

Prior approval is necessary before the Fund can make payment for this benefit.

The Fund will provide hospice care for relief of pain and supportive care to a covered terminally ill person with a life expectancy of two months or less when certified by a physician. Benefits will be provided for up to 60 days of care. Any payments made toward this benefit will be placed under the patient’s lifetime major medical allowance.

The Fund will pay 100% of the negotiated rate for participating network facilities, and providers. For non-participating facilities, and providers, the Fund will pay up to 80% of its usual, customary and reasonable daily fee allowance.

Payment for this benefit will accumulate towards the participant’s lifetime major medical allowance.

**Hospitalization Benefits**

**Emergency room care.** Please refer to the section in this book entitled “Emergency Room Care.”

**Inpatient care.** As a registered bed patient in any general hospital, you and your enrolled dependents are each eligible to receive 120 days of care. Your days of care may be used during one confinement or during several confinements. An additional 120 days become available to you or your dependents each time there has been a separation between confinements of 90 days or more.

If you are a hospital patient in a semiprivate room, your bed, board (including special diets) and general nursing care are covered in full for up to 120 days.

If you occupy a private room, you will receive for the 120-day period a daily allowance equal to the hospital’s average semiprivate room charge toward the cost of bed, board and general nursing care.

The following services are covered in full during the full benefit period, regardless of the class of accommodations occupied, if they are necessary for the diagnosis and treatment of the condition for which you are hospitalized. Fees for these services will not accumulate toward the participant’s lifetime major medical allowance.

**Hospital inpatient facility services include:**

- Semiprivate room and board for up to 120 days of care (Days of care may be used during one confinement or several). “Medical supplies” are covered under the fee for room and board.
- General nursing care.
- Meals and special diets.
- Use of operating room and related facilities.
- Use of intensive care or cardiac care units and related services.
- X-ray services.
- Laboratory and other diagnostic tests.
- Drugs and medications.
- Biologicals.
- Anesthesia and oxygen services.
- Short-term physical, speech and occupational therapy.
- Radiation therapy.
- Inhalation therapy.
- Chemotherapy.
- Whole blood and blood products.
- Administration of whole blood products.
- Physical therapy rehabilitation.
- Maternity care.
- Newborn care.
- Coverage for an inpatient hospital stay following a lymph node dissection, lumpectomy or mastectomy for the treatment of breast cancer.

Most hospitals contract with independent physicians, surgeons and medical professionals. These individuals are independent contractors and not on the hospital’s payroll. Therefore, do not assume that:

1. The physician fees are included in the hospital bill, and
2. That all medical providers assisting you during your inpatient hospital stay or surgery participate in the Plan’s provider network.

You should reference your physician handbook as well as the provider network web site to ascertain whether or not every medical professional being selected for your procedure is participating within the network, otherwise you most likely will be liable for any outstanding balance.

**Outpatient hospital* benefits.** Outpatient hospital facility charges for surgery are not subject to the deductible and are payable for participating network facilities at 100% of the Fund’s negotiated rate.

*Please note that the term “hospital” is used purposely and specifically. Surgeries performed in a surgical center will be paid according to the provisions set forth within the section of this book titled “Surgery Benefits.”

**Hospital Facility Outpatient services include:**

- Ambulatory surgery, tilt table testing, pulmonary function testing, mammography screening and breast sonograms in a hospital’s “outpatient” department.
- Pre-surgical testing when performed within 7 days of surgery in the same hospital that the surgery is to take place.
- Legitimate emergencies performed in the emergency room.
- Dialysis
Any additional medical services and supplies customarily provided by the hospital unless specifically excluded by the contract.

Non-participating ambulatory hospital surgical fees are not subject to the deductible paid at 100% of the Fund’s reasonable and customary fee schedules.

Out-patient services for tilt table testing, pulmonary function testing, mammography screening and breast sonograms must be performed in a participating facility in order for this Fund to make payment for that service. Services performed in a non-participating facility will be subject to the participant’s annual deductible and will be paid at 80% of the Fund’s usual, customary and reasonable fee schedule.

Participating facility hospital fees associated with the out-patient treatment of tilt–table testing, pulmonary function testing, mammography screening and breast sonograms are subject to the deductible paid at 100% of the Fund’s reasonable and customary fee schedules.

Other charges will be subject to the participant’s annual deductible and will be paid at 80% of the Fund’s usual, customary and reasonable fee schedule.

X-rays, MRIs, or laboratory testing MUST be performed in facilities other than a hospital.

House Call: Services for Members with Temporary Disability or Other Urgent Family Situations

If you become temporarily disabled – due to physical, emotional or mental health factors – you and your entire family can be affected. The illness of one person in the family has causes and effects that are often unnoticed, but they are factors that impact your family in many different ways.

The Trustees who oversee the Fund Plan understand this and have created the House Call benefit program in response to members’ needs.

What is House Call?

- It’s a “check-in” service, providing one or more telephone calls to you when you are out of work due to temporary disability or other family lifecycle events.
- The purpose of the calls is to make sure that you and your family are aware of all benefits provided by the Welfare Fund to help get your lives back to normal.
- House Call is free and confidential. A counselor calls you to let you know about benefits that exist within the Fund, or outside of the Fund, which may be of value in your particular situation.

What can House Call do for you and your family?

House Call counselors offer information and referrals which can help you and your family during a difficult time, including features of your benefit program that you may not have considered. For example, there are emotional and monetary issues that can come up while you are dealing with physical problems; and there are physical problems that can arise when you are dealing with stress.

The important thing is for you and your family to come through these problems in the best ways possible, and that often means dealing with the situation in more than just one way. And that is what House Call helps you do.

The Fund maintains the right to initiate the House Call program on your behalf when it is considered appropriate or necessary to help you. The decision to use the services that House Call counselors suggest is always up to you.

Not all situations will prompt this program. But always remember, YOU can “check in” with Work...
and Family Benefits whenever **YOU** want. You don’t have to wait to get a call – make the call: 1-800-328-4071.

**Infertility Benefits**

The Fund will allow $5,000 of the participant’s $10,000 lifetime Supplemental Medical Health Benefit to be used toward infertility treatments. All monies used toward infertility will be subtracted from the participant’s lifetime supplemental medical health benefit.

Participating provider charges will be subject to the deductible and payable at 100% of the negotiated rate up to the lifetime allowance of $5,000.

Non-participating provider charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule up to the lifetime allowance of $5,000.

The Fund will not make payment for any service rendered to any individual other than the member or legal spouse.

A participant’s infertility benefit cannot be combined with another participant’s infertility benefit to create a larger benefit.

Oocyte cryopreservation is not covered under the Plan.

**Lasik Surgery**

Prior approval is necessary before the Fund can make payment for this benefit. Therefore, it will be necessary to send in a letter of medical necessity from an ophthalmologist along with a complete medical report in order to determine that surgery is not being performed for any cosmetic reason.

The Fund will allow up to a maximum global allowance of $1,600 for each eye.

Participating provider charges will be subject to the deductible and payable at the negotiated rate up to the global allowance of $1,600.

Non-participating provider charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule up to the maximum global allowance of $1,600.

No payment will be made for this procedure if glasses or contact lenses can correct the optical condition.

The Fund reserves the right to require a second opinion for any surgical procedure or disability.

The Fund will not make any payment for this surgery if the primary reason the participant wants this procedure performed is because he or she no longer wants to wear glasses.

**Lithotripsy** (Removal of calcification in the bladder or urethra)

The Fund will allow up to a maximum global allowance of $6,000 for this procedure.
Participating provider charges will be subject to the deductible and payable at the negotiated rate up to the global allowance of $6,000.

Non-participating provider charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule up to the maximum global allowance of $6,000.

**Major Medical Allowance**

As an active member, your medical benefits are classified in the following manner:

1. Those benefits that accumulate under your lifetime major medical allowance of $125,000; and
2. Those benefits that do not accumulate toward your lifetime major medical allowance.

The following charges will not accumulate against your lifetime major medical allowance:

- Dental claims
- Prescription claims processed under the Rx plan.
- Vision claims
- Facility Charges associated with:
  - A participant’s emergency room visit (provided a true emergency)
  - Inpatient hospital stays as described under the hospitalization benefit section.
  - Inpatient stays for both mental health and substance abuse treatments.
  - Ambulatory surgery.
  - Acute physical and occupational rehabilitation after inpatient hospital stay.
  - 200 Lifetime home health care visits after Hospital Stay.
  - Dialysis.
  - Chemotherapy performed in a hospital.
  - Radiation therapy performed in a hospital.

(Typically, the charges or fees associated with these items are the most egregiously or excessively charged, and would max out the participant lifetime “cap” quickly if allowed to accumulate under the major medical provision.)

Allowances paid by this Fund for any other benefit will accumulate toward a participant’s lifetime major medical allowance.

For accounting purposes, an “expense” will be considered to have been incurred and therefore have accumulated toward an individual’s lifetime major medical allowance on the date that the claim is paid by the Fund. Regardless of the date when a claim was incurred, no payments will be made toward any claim received after that date that the individual exhausted his or her lifetime allowance.
With the exception of benefits that have lifetime limits, a provision has been established so that a member who has used at least $1,000 of his or her major medical benefits can have his or her maximum major medical benefits fully restored, provided that his or her doctor certifies that the member is physically able to return to work and provided that the member does return to work for a contributing employer and performs unit work within the jurisdiction of the I.U.O.E., Local 15, 15A, 15C and 15D. Dependents are not eligible to receive this provision.

Every participant should be aware of his or her major medical usage. If you believe that you are encroaching your lifetime major medical allowance, you should inquire with the Fund Office to find out how much of your major medical coverage still exists.

**Mammogram Testing**

The Fund will allow two mammographies per year for eligible participants.

If more than two mammographies are necessary, the Fund office must receive a letter of medical necessity prior to the service being rendered. If the Fund does not receive the letter of medical necessity prior to the service date, the Fund will not make any payment toward those mammographies.

Mammogram’s performed in a participating hospital or facility will be subject to the deductible and will be paid at 100% of the negotiated rate.

Mammogram’s performed in a non-participating hospital or facility will be subject to the deductible and will be paid at 80% of the usual, customary and reasonable fee schedule.

Mammograms performed in a non-participating private physician’s office will be subject to the deductible and will be paid at 80% of the Fund’s usual, customary and reasonable fee schedule.

The physician charge for the reading of the screening will be subject to the deductible and will be paid at 100% of either the negotiated rate for participating providers or 80% of the Fund’s usual, customary and reasonable fee schedule for non-participating providers.

**Maternity**

The Fund provides a benefit for surgical procedures, obstetrical procedures, preoperative and postoperative care on an inpatient and outpatient basis, performed by a physician, surgeon, specialist, certified nurse midwife, anesthetist or anesthesiologist.

Services and supplies for maternity care provided by a physician, hospital or birthing center are covered for prenatal care (including one visit for genetic testing), postnatal care, delivery and complications of pregnancy.

The Fund will pay for three sonograms during a pregnancy. Any sonogram beyond the three will not be paid unless the fund Office receives a letter of medical necessity and approves the additional sonograms prior to the additional sonograms being rendered. Additional sonograms used to determine sex, size, weight of the fetus, or timing of the delivery are not considered medically necessary and will not be covered.
The Fund does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section or require that a provider obtain authorization from the Plan prescribing a length of stay not in excess of these time frames.

However, the mother’s or newborn’s health care practitioner, after consulting with the mother, can discharge the mother or newborn child earlier than 48 hours or 96 hours, as applicable. If the mother decides to be discharged earlier than the aforementioned time periods, she shall be entitled to one home care visit, which shall be delivered within 24 hours after the discharge or the time of the request. The home visit consists of a visit by a professional registered nurse to provide the following post-delivery care:

- An assessment of the mother and child; and
- Any required blood tests ordered by the mother’s or the child’s physician.

This home care visit is in addition to any other home care benefits described in this manual.

The following benefits are paid at time of delivery:

- For a normal and/or caesarean section delivery, the Fund will allow up to 100% of the negotiated rate for network affiliated midwives or participating providers. Deductible applies.
- For normal delivery, the Fund will allow up to a global rate of $3,600.00 for non-network affiliated physicians. Deductible applies.
- For normal delivery, the Fund will allow up to a global rate of $3,200.00 for non-network affiliated midwives. Deductible applies.
- For caesarean section delivery performed by a non-network affiliated physician the Fund will allow up to a global rate of $4,000. Deductible applies.
- For a non-emergency miscarriage performed by a participating physician, the Fund will pay 100% of the negotiated rate. Deductible applies.
- For a non-emergency miscarriage performed by a non-participating physician, the Fund will pay 80% of the Fund’s usual, customary and reasonable fee schedule. Deductible applies.

The Fund will not pay for services and supplies for maternity care provided by a hospital or birthing center that includes parent education, assistance and training in breastfeeding or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

The Fund will not pay for anesthesia administered by the operating surgeon, the surgeon’s assistant or an employee of a hospital or similar institution or a Certified Registered Nurse Anesthesiologist (CRNA).

Termination of pregnancy (abortion). Therapeutic abortions and non-therapeutic abortions are covered. For participating providers, the Fund will pay 100% of the negotiated rate after the deductible has been met.

Services performed by non-participating providers will be paid at 80% of the Funds usual, customary and reasonable fee schedule. Deductible applies.
Facility charges for services performed within a participating hospital, participating acute surgery center or participating acute surgery facility are paid at 100% of the negotiated rate.

Facility charges for services performed in a non-participating hospital or facility will remain the responsibility of the participant.

**Mental Health**

**Inpatient**

**Outpatient**

**Inpatient care.** Prior approval is necessary before the Fund can make payment for this benefit.

Participants are allowed a maximum of two inpatient stays per lifetime for mental health rehabilitation. There is a 30-consecutive day maximum per inpatient stay, per calendar year for any inpatient mental health rehabilitation treatment in any mental health rehabilitation facility.

Any inpatient stay, regardless of time (greater than one day but not to exceed 30 consecutive days), will be considered toward the participant’s lifetime inpatient benefit.

If there exists a break between inpatient rehabilitation, it will be considered a separate inpatient stay and count toward the participant’s lifetime inpatient benefit.

Inpatient treatments performed in a participating facility will be paid according to the Fund’s negotiated rate.

The Fund will make payments for services performed only by a psychiatrist, licensed social worker, certified social worker or clinical psychologist, and only after prior written approval from the Fund.

All inpatient treatments performed in a non-participating facility will be paid according to the rate mutually agreed upon by the facility and the Fund.

If the Fund and the non-participating facility cannot mutually agree to a rate, the Welfare Fund will notify both the participant and the facility of what the Funds allowance is. Any balance remaining beyond the Funds payment will remain the responsibility of the participant.

All money paid toward inpatient mental health treatments will not accrue toward the participant’s lifetime major medical allowance.

Inpatient treatments performed by a participating, duly licensed psychiatrist or psychologist, licensed social worker, certified social worker or clinical psychologist will be subject to the deductible and paid at 100% of the Fund’s contracted rate. Fees for provider services will accumulate toward the participant’s lifetime major medical allowance.

Reimbursement for inpatient treatments performed by non-participating, duly licensed psychiatrists or psychologists, licensed social worker, certified social worker or clinical psychologist will be subject to the deductible and paid according to the Fund’s usual, customary and reasonable fee schedule. Fees for provider services will accumulate toward the participant’s lifetime major medical allowance.
No payment will be made for:

- Any treatment that is mandated by a court or federal agency because the individual attempted to commit, or there was a commission of, a misdemeanor or felony, or participation in a public disturbance or riot.

- Any treatments or conditions that are not organic.

- Care following a drug or alcohol-related arrest.

- Treatment that is the result of externally induced chemical agents. Rehabilitation programs related to alcohol and substance abuse are not considered mental health services under this provision.

- Any services that are rendered prior to the Fund’s written approval for treatment. In order to receive written approval, and hence payment for these benefits, the member is required to mail or fax into the Fund prior to that treatment the attending physician’s written description of the present illness together with a treatment plan which includes an estimated length of treatment.

- Any services that are rendered by someone other than a social worker, a practicing psychologist or a duly licensed psychiatrist.

- Any service that exceeds the lifetime maximum benefit of 60 inpatient visits.

- If the individual leaves an inpatient program against the medical advice of a physician, the Welfare Fund will not make any payment for the services that were provided. Consequently, the patient will be responsible for the total amount of the bill.

**Outpatient care.**

Prior approval is necessary before the Fund can make payment for this benefit. In order to receive approval, the member is required to mail or fax into the Fund prior to that treatment the attending psychiatrist’s and/or psychologist’s written description of the present illness together with a diagnosis code and treatment plan which includes length of treatment.

**Important:** Letters of medical necessity must be renewed annually by a psychiatrist or psychologist. Therefore, if you are receiving ongoing treatments for mental health from a year prior to a new calendar year, you will have to submit a new letter of medical necessity into the Fund prior to continuing treatment.

The Fund allows up to a maximum of 36 visits per calendar year for outpatient mental health treatments, provided they are rendered by a social worker, a practicing psychologist or a duly licensed psychiatrist.

All mental health outpatient visits will be combined with outpatient visits for alcohol and substance abuse and medication management. The total combined maximum is 36 visits per calendar year.

The Fund will make payments for services performed only by a psychiatrist, licensed social worker, certified social worker or clinical psychologist, and only after prior written approval from the Fund. **Deductible applies and payments provided by this Fund will accumulate towards the participant’s lifetime Major Medical allowance.**

Participating providers will be subject to the deductible and payable at 100% of the negotiated rate.
Non-participating providers are subject to the deductible and will be paid as follows:

- Psychiatrist, psychologist: $100 a visit
- Social Worker: $70 a visit
- Group Therapy performed by a Psychiatrist, Psychologist, or Social Worker: $45 a visit
- Family Therapy performed by a Psychiatrist, Psychologist, or Social Worker: $45 a visit

All pharmaceutical management visits must be provided by a medical doctor (MD), a psychiatrist/psychologist, and will be paid at the rates listed above. These visits will count toward the participant’s annual maximum allowable mental health visits.

No payment will be made for:

- Any treatments or conditions that are not organic.
- Any treatment that is associated with marriage counseling or relationship issues.
- Any treatment that is mandated by a court or federal agency because the individual attempted to commit, or there was a commission of, a misdemeanor or felony, or participation in a public disturbance or riot.
- Treatment that is the result of externally induced chemical agents. Rehabilitation programs related to alcoholism and substance abuse are not considered mental health services under this provision. They are considered Drug, Alcohol and Substance Abuse.
- Any services that are billed by a hospital or a hospital-affiliated facility, such as a clinic, or attached outpatient medical facility.
- Any service that is rendered by someone other than a social worker, a practicing psychologist or a duly licensed psychiatrist.
- Any other individual with other credentials or a religious or spiritual individual.
- Intensive Psychiatric Rehabilitation Treatment (IPRT).
- Intensive Outpatient Rehabilitation (IOT).
Newborn Care (SEE MATERNITY FOR NEWBORN HOSPITAL ALLOWANCE)

Care for newborns includes preventive health care services, routine nursery care, circumcisions and treatment of disease and injury. Treatment of disease and injury includes treatment of prematurity and medically diagnosed congenital defects and birth abnormalities, which cause anatomical functional impairment.

Participating provider charges will be subject to the deductible and payable at the negotiated rate.

Non-participating provider charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule.

Neuropsychological Testing

Prior approval is necessary before the Fund can make payment for this benefit.

The Fund will allow up to a maximum allowance of 12 units per test, per calendar year, based on medical necessity. A “unit” is defined as an hour.

Participating provider charges will be subject to the deductible and payable at 100% of the negotiated rate.

Non-participating provider charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule.

Nutritionist/Dietician

The Fund will allow up to six visits per calendar year for services and 18 lifetime visits performed by a nutritionist who holds a master of science (MS) in nutrition from an accredited university.

For participating providers, charges will be subject to the deductible and paid at 100% of the negotiated rate.

For non-participating providers, charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule.

Please note: If you are looking for nutrition counseling, we recommend checking the individual’s professional credentials to be sure he or she has a degree in nutrition, because “nutritionist” is an unregulated term and doesn’t have minimum requirements. Anyone can call oneself a “nutritionist” or receive a certificate from a school in nutrition.

Any visit to a nutritionist will be combined with any service provided by a dietician during the year, not to exceed the six visits per year and the 18 lifetime visits.
Occupational Disease, Illness or Injury

Please refer to the section of this book entitled “Workers’ Compensation.”

Important: For the sole purpose of identifying workers’ compensation claims from claims that are truly the obligation of the Welfare Fund, certain conditions, illnesses, procedures and therapies have been flagged. If the Welfare Fund identifies one of these flagged items on a medical claim that was submitted on your behalf, adjudication of the claim will cease and the Fund will forward to the participant a verification letter to confirm that the services rendered were not work related.

If the claim is work related, proceed to the section of this book entitled “Workers’ Compensation,” and complete and return the verification letter.

If the claim is not work related, complete and return the form. After receipt of the verification letter, adjudication on the claim will commence.

If the Fund does not receive the completed form within 90 days of the date of issuance of the notice, the claim will not be paid. Payment for the services rendered will be the responsibility of the participant.

Claimants are reminded that they will be subject to the rules and provisions of this Funds Fraud and Abuse policy for any misrepresentation.

Occupational Therapy

Inpatient

Outpatient

Inpatient care. Admission to a rehabilitation facility requires prior approval.

Inpatient rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, will be provided if care begins immediately after discharge from a hospital. Inpatient rehabilitation therapy is limited to one consecutive 30-day period, per condition, per calendar year in a rehabilitation facility that has programs approved by the New York State Department of Health, or similar state agency.

Speech or occupational therapy is covered only when it is necessary to correct a condition that is the result of a disease, injury, stroke or a congenital defect.

All inpatient rehabilitation therapy must be performed at network hospitals that have been specifically approved and designated to perform these procedures or services.

Payment for treatment will only occur provided the treatment services began immediately after discharge from a hospital, and provided prior approval is obtained.

No payment will be made for:

- Any service that is rendered by a non-licensed physiotherapist.
- Any services that are billed by a non-participating hospital or hospital-affiliated facility, such as a clinic, or attached outpatient medical facility.

Any therapy benefit that continues beyond the 30-day maximum inpatient annual allowance.

Payments made by this Fund towards a participant's inpatient care will not accumulate toward that participant's lifetime major medical allowance.

**Outpatient Occupational Therapy**

**Outpatient care.** Prior approval is necessary before the Fund can make payment for this benefit. Deductible applies.

The Fund provides a lifetime allowance of $4,000 per illness/diagnosis for treatments by a physiotherapist or doctors of osteopathy.

The Fund allows up to $50 per day for all visits, manipulations and modalities for all non-participating physiotherapists or doctors of osteopathy.

For participating physiotherapists or doctors of osteopathy the Fund will pay 100% of the negotiated rate with no daily limitations.

No payment will be made for:

- Any services that are rendered prior to the Fund's written approval for treatment.
- Any service that is rendered by a non-licensed physiotherapist or doctors of osteopathy.
- Any services rendered by a podiatrist or chiropractor.
- Any service rendered after the participant's lifetime allowance has been exhausted regardless of this Fund's approval.

Payment for services for outpatient treatment will accumulate toward that participant's lifetime major medical allowance.

**Organ Transplants**

In order to receive benefits,

1. Prior approval is required, and
2. Benefits must be coordinated with this Fund's Catastrophic Case Management provision, and
3. All transplants must be performed at network hospitals that have been specifically approved and designated to perform these procedures.

The Fund will cover only those transplants that it determines to be non-experimental and non-investigational. If alternative remedies are not available, benefits will be provided for the following transplant surgeries for the following body organs:

- Bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich syndrome.
- Cornea.
- Heart.
- Heart/lung.
- Kidney.
- Liver.
- Pancreas (when the condition is not treatable by use of insulin therapy).

Recipieent:

Benefits are provided for recipient expenses. A “recipient” is an individual who undergoes a surgical operation to receive a body organ transplant.

For surgeons that participate within the network, the deductible applies. The Fund will pay 100% of the negotiated rate.

For surgeons that do not participate, the deductible applies. The Fund will pay 80% of the Fund’s usual, customary and reasonable fee schedule.

Donor:

Benefits for donor expenses are limited to donors who donate an organ to recipients who are covered participants under the Local 15 Welfare Fund.

Participating surgeon charges will be subject to the deductible and payable at 100% of the negotiated rate.

Non-participating surgeon charges are subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule.

The Fund does not cover:

- Travel expenses, lodging, meals or other accommodations for donors or guests.
- Donor search fees.
- The expenses of a member acting as a donor for a non-participant of the Plan.

Orthotics

Prior approval is necessary before the Fund can make payment for this benefit.

The Fund provides a lifetime allowance of $1,000 for this benefit. All payments will be applied to the participant’s lifetime major medical allowance.
Orthotripsy (Bone Spurs, etc)

Prior approval is necessary before the Fund can make payment for this benefit. Therefore, it will be necessary that your doctor or surgeon send in a letter of medical necessity including diagnosis code(s).

A second opinion is required with a participating Orthopedic physician.

The Fund will allow up to a maximum global allowance of $4,000 for this procedure.

Participating provider charges will be subject to the deductible, and payable at the negotiated rate up to the global allowance of $4,000.

Non-participating providers’ charges will be subject to the deductible, and payable at 80% of the Fund’s usual, customary and reasonable fee schedule up to the maximum global allowance of $4,000.

Pharmacy Benefits

After a calendar year drug deductible of $25.00 per person, prescriptions are reimbursed at 80% of the balance of the cost of the prescription or refill to a maximum of $1,700 in a calendar year.

The drug deductible of $25.00 and the maximum benefit apply to each member and each dependent.

The Fund does not cover over-the-counter medication or experimental pharmaceuticals under this benefit provision.

Caremark mail service program.

You should use the mail order program when you need to have Prescriptions filled for maintenance medications. Maintenance medications are Prescription drugs that are used on an ongoing basis. These Prescriptions can be used to treat chronic illnesses such as arthritis, diabetes, or high blood pressure. The mail order program provides a safe, convenient way for you to have your medications delivered right to your home.

The mail service program offers a cost-effective way of providing a three-month supply of maintenance and long-term care prescriptions.

A doctor’s prescription for a 90-day supply, plus three refills, is required. After submission of the first prescription to the Caremark Mail Service, refills can be obtained:

- By telephone, using the number on the back of your identification card or in your benefit plan description.
- By mail, using the order form.
Generic Equivalents and Brand Name Medications

Many prescription drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. On average, generic medications can save about half the cost of the brand name medications, but for some medications this savings can be as great as 90%. This can be a significant source of savings for you and the Fund. In general, the savings achieved by using generic medications will help control the cost of health care while providing quality medications.

You should discuss with your Physician if a generic equivalent is available, and appropriate, for any Prescriptions you need filled. Your Physician or pharmacist can assist you in substituting generic medications when appropriate.

While you pay the same percentage of your covered Prescription drug expenses, whether you receive a generic medication or a brand name medication, since brand name medications cost more, you pay more because you’re paying the same percentage of a higher amount. The Fund encourages you to use generic medications whenever possible to lower the amount you pay.

Pharmacogenetic Testing

Pharmacogenetics is the tailoring of medications to an individual’s genetic profile.

Prior approval is necessary before the Fund can make payment for this benefit. Therefore, it will be necessary to send in a letter of medical necessity along with a complete medical report in order to determine that a pharmacogenetic test is required.

The Fund provides a lifetime allowance of $1,000 for this benefit. All payments will be applied to the participant’s lifetime major medical allowance.

The Welfare Fund will only make payments toward pharmacogenetic tests taken by a physician. No benefit will be made for direct to consumer genetic testing.

(Participants wishing to utilize the direct to consumer genetic test should be aware that the American Medical Association discourages direct to consumer genetic testing and recommends that States ban them, as New Jersey, New York, and Rhode Island already have. Additionally, the federal government does not regulate the safety and accuracy of most genetic tests and has only minimum standards in place for genetic testing laboratories.)

Physician Benefits

For participating providers, the $100.00 deductible applies. The Fund will pay 100% of the negotiated rate for a covered service under the Plan.

For non-participating providers, the $100.00 deductible applies. The Fund will pay 80% of the Fund’s usual, customary and reasonable fee schedule for a covered service under the Plan.

The Fund will not make any payment for services after the participant’s lifetime major medical maximum allowance has been met.
Some services and treatments have fixed allowances regardless of the network affiliation of the provider. Consequently, the Fund will not pay beyond the limits and allowances set forth within this book.

Additionally, some services and treatments require prior approval by the Fund. (See specific benefit sections in this manual). The Fund will not make payments for services that are rendered prior to the Fund’s written approval for the particular treatment or service. In order to receive written approval, and hence payment for these benefits, the member is required to mail or fax into the Fund prior to that treatment or service the attending physician’s or surgeon’s written description of the present illness, together with a complete medical report and treatment plan.

**Physiotherapy, Treatments, Physical Rehabilitation, Occupational and Speech Therapy Benefits**

**Inpatient**

**Outpatient**

**Inpatient care.** Admission to a rehabilitation facility requires prior approval.

Inpatient rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, will be provided if care begins immediately after discharge from a hospital. Inpatient rehabilitation therapy is limited to one consecutive 30-day period, per condition, per calendar year in a rehabilitation facility that has programs approved by the New York State Department of Health, or similar state agency.

Speech or occupational therapy is covered only when it is necessary to correct a condition that is the result of a disease, injury, stroke or a congenital defect.

All inpatient rehabilitation therapy must be performed at network hospitals that have been specifically approved and designated to perform these procedures or services.

Payment for treatment will only occur provided the treatment services began immediately after the date of discharge from a hospital, and provided prior approval is obtained.

No payment will be made for:

- Any service that is rendered by a non-licensed physiotherapist.
- Any services that are billed by a non-participating hospital or facility, such as a clinic, or attached outpatient medical facility.
- Any therapy benefit that continues beyond the 30-day maximum inpatient annual allowance.

Payments made by this Fund towards a participants inpatient care will not accumulate toward that participant’s lifetime major medical allowance.

**Outpatient care.** Prior approval is necessary before the Fund can make payment for this benefit. Any services performed prior to approval will not be covered.
The Fund provides a lifetime allowance of $4,000 per illness/diagnosis for treatments by a physiotherapist.

For participating physiotherapists or doctors of osteopathy, licensed physical therapist or physiologist, the Fund will pay at the negotiated rate with no daily limitations.

For non-participating physiotherapists, doctors of osteopathy, licensed physical therapists or physiologists, the Fund allows up to $50 per day for all visits, manipulations and modalities.

No payment will be made for:

- Any services that are rendered prior to the Fund’s written approval for treatment.
- Any service that is rendered by a non-licensed physiotherapist or doctors of osteopathy.
- Any physical therapy services rendered by a podiatrist or chiropractor.

Payment for services for outpatient treatment will accumulate toward that participant’s lifetime major medical allowance.

Podiatry

A second opinion and prior approval by a medical doctor is required for any surgical procedures.

For podiatrists that participate within the network, the Fund will pay 100% of the negotiated rate. Deductible applies.

For podiatrists that do not participate within the network, the Fund will pay 80% of the Fund’s usual, customary and reasonable fee schedule. Deductible applies.

The Fund will not make payment for physical therapy or strapping’s performed by a Podiatrist.

Pretreatment Estimates

Pretreatment Estimate is a predetermination of the benefits payable by the Plan. Predetermination of benefits helps you avoid surprises by letting you and your provider know in advance what services are covered and what payment will be made by the Fund.

If you wish to know, in advance, if the charges of your provider are considered usual, customary and reasonable by the Fund or if you have a series of dental treatments that is expected to cost more than $200.00, it may be to your advantage to ask your provider to submit a request for a pretreatment estimate to the Fund Office. This will ensure that you know which services and materials are covered and how much will be paid by this Fund and how much out of pocket expenses you may incur.
Caution: It is in your best interest not to sign any form that says you will accept responsibility for any part of the charges not paid by your insurance. Benefit payments are based on usual, customary and reasonable accepted fees. If the provider charges an amount over the usual, customary and reasonable accepted fee and you have signed the form indicating you are responsible for any amount the Plan does not pay, you have no recourse and will be required to pay the balance.

Preferred Provider Organization (PPO – In-network physicians and providers)

To help manage certain health care expenses, the Plan contains a cost management feature – the Preferred Provider Organization (PPO) network.

The Providers (Physicians, Hospitals, and other professional health care providers) participating in the PPO network (Preferred Providers) have agreed to negotiated, reduced fees. When you use a Preferred Provider or In-network provider, you save money for yourself and the Plan because Preferred Providers or In-network providers have agreed to charge a reduced amount for their services.

The Trustees understand that health care is a very personal issue and sometimes you might feel better going to a certain provider that does not participate in the Plan’s PPO network. The preferred /non-preferred (or in-network / out of network) feature of this Plan accommodates these circumstances. Each time you receive medical care, you can choose whether or not to use an In-network provider. However, remember that to encourage you to use an In-network provider whenever possible, the Plan pays a higher percentage of your health care expenses when you go to an In-network or Preferred Provider.

To take advantage of the savings the PPO provides you must check to see if your provider is in the network. (Providers participating in the network change periodically.) And, you must show your medical identification card at the time that you receive services.

Finding a Preferred Provider or In-network provider is easy, you can request a provider directory form the Fund Office or, for the most up-to-date information, you can access benefitfunds.iuoe15.org and click on icon for the PPO.

The Trustees have tried to supply the participants with a PPO network robust enough to provide an In-network or Preferred Provider for just about any type of health care practitioner you and your family will ever need. However, the fact remains that some medical specialties may not be well represented within the network or in the area in which you reside. Consequently, you may find yourself needing to access an out-of-network provider for the services you seek. Participants who find themselves in this situation are reminded that payment for these services will be made in accordance to the out-of-network provisions of this Plan.

If you are a participant who has settled in an area that has limited or no In-network medical facilities or medical practitioners to utilize, the Fund wants you to understand that:

1. With little or no demographical leverage by either the Fund or it’s contracted Preferred Providers Network, it is very difficult to organize the regional providers to participate within the contracted PPO Network.

2. Without robust regional competition within the specialty of the physician you are utilizing, it is very difficult to get the physician to participate within the PPO network.
3. The reasons why you reside where you do are precisely the reasons why the PPO networks are not lured to establish a network in your area. It takes money to establish and maintain a network. In areas sparsely populated, the PPO networks cannot make profits that support their business model.

**Benefit for Non-Participating Providers will be paid in accordance to the out-of-network provisions of this Plan.**

Finding a network doctor – whenever you need one – has never been easier. Just a click of the mouse on the Funds website can link you to the online provider directory. It’s open for business anytime you need it, to give you information you can use to select a doctor who’s right for you.

**benefitfunds.iuoe15.org** provides details on each health care professional, including:

- Location.
- Specialties.
- Languages spoken.
- Hospital affiliation.
- Gender, and more.

If you prefer a printed directory, simply call Member services at 212 – 255-7657.

**Prior Approval**

Prior approval is required from the Welfare Fund in order for the Fund to make payments toward the following benefits:

- Bariatric/gastric bypass
- Cardiac rehabilitation
- Dental work performed in a hospital setting
- Durable medical equipment
- Drugs related to Cancer, Hepatitis C and AIDS, MS and Diabetes
- Epidural injections/nerve blockers
- Home health care
- Hospice
- Inpatient rehabilitation
- LASIK surgery (eyes)
- Mental health benefits*
- More than 3 maternity sonograms
- Nasal Surgery
- Neuropsychological testing
- Occupational/physical/speech therapy
- Orthotics
- Orthotripsy
- Pharmacogenetics
- Podiatric surgery
- Private Duty Nursing
- Prosthetics
- Pulmonary Rehabilitation
- Reconstructive surgery and corrective surgery
- Sclerosis
- Skilled nursing benefits
- Sleep study
- Substance abuse treatments
- Synagis Injections
- Vein Therapy
- Wigs

*Outpatient mental health and substance abuse treatments must be approved annually. Treatments that span into a new calendar year without approval from the Fund will remain the responsibility of the participant. Payment will be made according to the provisions set forth within that specific benefit for the services rendered after the letter of medical necessity has been received and ongoing treatment approved.

You are responsible for obtaining any required prior authorization.

All requests for prior authorization must be made by a physician, in writing, mailed or faxed to 212-675-8303 and received prior to the time treatment is rendered. The request must include the physician’s written description of the present illness (including diagnosis code), together with a treatment plan and estimated length of treatment. This request or document is called a letter of medical necessity. If there is a problem with the written request, one of the Fund’s claims specialists will consult with your physician. This evaluation assures that the treatment you receive is appropriate for your needs and is delivered in the most cost-effective manner.

If you are about to be discharged from an inpatient hospital stay and you require home care, hospice, skilled nursing, rehabilitation benefits or durable medical equipment, you should call (212) 255-7657 and secure a prior approval from a Welfare Fund claims specialist.

If you require emergency medical treatment for detoxification, and you are admitted to a hospital in the night or on a non-business day, prior authorization must be attained on the very next business day. Please fax your request to (212) 675-8303 the following business day.

Any pre-certification and prior authorization you receive will not be valid if your coverage under the Plan terminates. This means that covered services received after your coverage has terminated will not be covered even if they were pre-certified or authorized (unless coverage is being continued in accordance with COBRA).
Any treatment prescribed by the physician will not be covered if treatment is not rendered within 30 calendar days from the date of the prescription being written.

The Fund reserves the right to require a second opinion for any of the above treatments or services.

Any payment made by the Fund will not exceed the limits and provisions that are identified within this book.

Any services rendered prior to the written approval of the Fund, will remain the responsibility of the participant.

**Privacy Practices/HIPAA**

Please refer to the section at the end of the book entitled “Notice of Privacy Practice” under the section “Other Plan Information”.

**Private Duty Nursing** (See Supplemental Medical Health Benefit)

Deductible applies. The Fund will not make payment toward any services that are rendered prior to the Fund’s written approval.

This benefit is provided under the Fund’s supplemental medical health benefit. All charges for private nursing services will be combined with the participant’s supplemental medical health benefit not to exceed a maximum lifetime allowance of $10,000 per participant.

Services prescribed by your physician that are performed by participating registered nurse will be paid at 100% of the negotiated rate not to exceed the limits previous described.

The Fund will make payments for services prescribed by your physician that are performed by a registered nurse, at 80% of the Fund’s usual, customary and reasonable fee schedule not to exceed the limits outlined previously.

**Prosthetics**

Prior approval is required before the Fund can make payment for this benefit. For participants who have undergone a mastectomy, the Fund will allow up to two bras and two prosthetics per calendar year.

For participants who have lost a limb, or eye, a prosthetic will be provided by the Fund up to, but not exceed, the Fund’s reasonable and customary fee schedule.

Participating providers are subject to the deductible and payable at 100% of the negotiated rate.

Non-participating providers are subject to the deductible and paid at 80% of the Fund’s usual, customary and reasonable fee schedule.
Reciprocity

The Fund has made arrangements with other Northeastern Operating Engineers Health Funds for transfer of Employer contributions to a Participant’s home Fund. This agreement was established in order to preserve eligibility and to provide continuity of medical coverage for you as a member in your home local’s welfare fund, regardless of where you may work in the Northeastern District of the International Union of Operating Engineers, provided, of course, you are working for a contributing employer doing unit work within the jurisdiction of the out-of-town Local and in accordance to their collective bargaining agreements.

The Northeastern District of the International Union of Operating Engineers is covered by the following welfare funds:

- Local 4 (Boston, MA)
- Local 14 (New York, NY)
- Locals 17, 106, 410, 463, 545, and 832 (New York state)
- Local 25 (Brooklyn, NY)
- Local 57 (Providence, RI)
- Local 66 (Pittsburgh, PA)
- Local 98 (Springfield, MA)
- Local 137 (Briarcliff Manor, NY)
- Local 138 (Nassau & Suffolk Counties, Long Island, NY)
- Local 478 (Hamden, CT)
- Local 542 (Philadelphia, PA)
- Local 825 (Newark, NJ and Newburgh, NY)

It is your responsibility to notify the Local 15, 15A, 15C & 15D Fund Office when you are employed out of town, indicating the number of the local under whose jurisdiction you are working, employer and the period worked.

Reconstructive and Corrective Surgery

Prior approval is necessary before the Fund can make payment for this benefit. Therefore, it will be necessary to mail or fax to the Fund a letter of medical necessity along with a complete medical report in order to determine that the surgery is not being performed for any cosmetic reason.

Reconstructive and corrective surgery is covered only when:

- The surgery is incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- The surgery is performed to correct a congenital birth defect of a dependent child which has resulted in a functional defect.

All services must be performed within two years of the event that caused the dysfunction.

Breast reconstruction, including surgery on the healthy breast to restore and achieve symmetry or implanted breast prostheses, are covered following a covered mastectomy.

Participating provider charges will be subject to the deductible and payable at 100% of the negotiated rate.
Non-participating provider charges will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule.

Federal law requires health insurance carriers of group and individual commercial policies that cover mastectomies to cover reconstructive surgery or related services following a mastectomy.

The Women’s Health and Cancer Rights Act of 1998 essentially guarantees coverage to any member who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with that mastectomy.

Under this law, the Fund is required to provide coverage for:

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

The Fund will not make any payment for services that are performed after 24 months of the event that caused the dysfunction.

September 11th, 2001

The Fund cannot urge enough the necessity for recovery and rescue workers of September 11, 2001 and subsequent months to remain current of the most recent information, services and support available by going online to www.NYC.gov.

The Fund also urges you to participate in the “World Trade Center Medical Monitoring Program”. For more information on this program, please refer to the section of the book by the same title.

Second Opinions

One of the most important steps you can take for yourself is to make sure that the recommended medical procedure is actually necessary. Getting a second opinion is an excellent way to become more informed about the procedure and the expected outcome, and an excellent method to discover if there exists another alternative available for you.

Benefits for the second opinion provision will be paid according to benefits already outlined in the section of the book titled “Physician Benefits.”

The Fund reserves the right to require a second opinion for any surgical procedure or disability. If a second opinion is required, the Fund reserves the right to refer you to a provider for that second opinion. The Deductible will not apply to this second opinion.

In the event that the first and second opinions differ, a third opinion will be required. The Fund will designate a new provider. The third opinion will determine whether or not the surgery is necessary or whether a disability payment should be continued. The Deductible will not apply to this third opinion.

If the Fund requires a second or third opinion, there will be no cost to you for that second or third opinion.
If a second or third opinion is required or requested by the Welfare Fund and the member, spouse or dependent does not comply, that member will lose his or her benefit of payment by the Fund for the hospital and physician fees for that surgery and/or lose his or her disability payment.

**Skilled Nursing Facilities**

Prior approval is necessary before the Fund can make payment for this benefit.

This Fund will allow up to 30 days per lifetime of care in a skilled nursing facility.

Entry into a skilled nursing facility will be approved when the following conditions have been met:

1. The patient has had at least 3 consecutive days of inpatient hospitalization.
2. Entry occurs immediately after discharge from an inpatient hospitalization.

The Fund will pay 100% of the negotiated rate for participating network facilities.

For non-participating facilities the Fund will pay up to 80% of its usual, customary and reasonable daily fee allowance.

All fees and charges will be accumulated toward the participant’s lifetime major medical allowance.

Payment for services received prior to the Fund’s authorization will remain the responsibility of the participant.

**Sleep Study**

The Fund will cover two sleep studies per calendar year. The first, for the diagnosis of Sleep Apnea, and the second, to titrate the C-PAP machine. This Fund’s usual, customary and reasonable global fee is $1,500.00. Prior approval is required.

Participating and non-participating provider charges will be subject to the deductible and payable up to 100% of the Fund’s usual, customary and reasonable global fee of $1,500.

**Subrogation**

No benefits shall be paid by the Fund for covered medical expenses, disability income benefits or any other benefit, which are included or includable by any claim or lawsuit instituted by a participant or dependent against any third party. The Fund may advance an amount up to the maximum benefit otherwise payable, provided the claimant subrogates the Fund to the extent of such advance. In any event, to recover any such advance payments, the Fund will impose a lien on any award or payment made in settlement of such a claim or lawsuit.

**Member Responsibility:** Participants must notify the Welfare Fund within 30 days of their initial illness or injury if the illness or injury was the result of a third party’s wrongful act, negligence, or if there exists a third party which may have a financial obligation to make restitution.
All notifications must be in writing and mailed to the Fund Office to the attention of the Fund Administrator. Said notifications must contain a description of the illness or injury, including dates and times, as well as the names and addresses of the parties involved, including the name and address of a third party’s legal representation.

The Fund reserves the right for its own counsel to review all documentation to determine the appropriateness of bringing legal action. Any legal expense incurred by the Fund for this review will be recoverable as part of any award.

Notice: Before the Plan pays any benefits on you or your dependent’s behalf, you must:

1. Agree in writing to pursue your claims against the third party, or to allow the Fund to pursue the claims on your behalf before any benefits are paid under this Plan.
2. Agree in writing that the Plan will be reimbursed in full, including for its own costs or attorneys fees prompted by this event.
3. Agree in writing that you will not take any action that would either jeopardize or prejudice the Welfare Fund’s subrogation rights.
4. Agree in writing that you will cooperate in doing what is reasonable and necessary to assist the Welfare Fund in any recovery.

Be advised that the Fund reserves the right to seek recovery of any amounts you receive from a third party even if you fail to inform the Fund of your claim or you fail to sign an Agreement with the Fund.

CAUTION: If the Fund Office discovers that:

1. The participant falsely filed a claim with the Fund Office instead of a third party, or a third party’s insurance company, or
2. If the Fund pays benefits to or on behalf of you or your dependents and you do not reimburse the Plan within 45-days after you receive benefits or payment from the third party,

The Welfare Fund reserves the right to take any or all of the following actions:

1. Withhold any other benefits that may be payable to you or your dependents, and/or
2. Take legal action against you, in order to recover the amount paid, legal fees, administrative costs, plus interest, and/or
3. Contact appropriate authorities about criminal proceedings.

Substance Abuse

Inpatient

Outpatient

Prior approval is necessary before the Fund can make payment for this benefit. You will be required to forward to the Fund for review the facility or physician’s assessment of medical necessity along with the diagnosis and treatment plan. A physician must sign all facility assessments.
Inpatient care. This benefit is available for all eligible members, their spouses and eligible dependents, who have been participants of the Fund for 24 months from their initial benefit eligibility date.

Participants are allowed a maximum of two (2) inpatient stays per lifetime. Typically, there is up to a 30-consecutive day maximum per inpatient stay, per year for any inpatient detoxification and/or rehabilitation treatment in any approved alcohol and drug rehabilitation facility.

Any day spent in detoxification and/or rehabilitation will be considered toward the two-inpatient stay lifetime maximum.

Any inpatient stay, regardless of time (greater than one day but not to exceed 30 consecutive days), will not be considered toward the participant’s lifetime inpatient benefit.

If there exists a break between detoxification and inpatient rehabilitation, it will be considered a separate inpatient stay and count toward the participant’s lifetime inpatient benefit.

Any day spent in detoxification will be counted toward the 30-day maximum.

There is a 4-day maximum per benefit period for detoxification in a hospital or rehabilitation center.

All inpatient services in any facility, participating or not participating, will be paid at an all-inclusive rate to be negotiated by the Fund. Any expenses above the Fund’s maximum will be the patient’s responsibility.

If you required emergency medical treatment for detoxification, and were admitted to a hospital, prior authorization can be obtained by telephone on the very next business day.

Inpatient treatment for alcohol or drug abuse must take place in a licensed institution that meets all of the following conditions:

- Is primarily established for the treatment of alcoholism or drug abuse;
- Provides a program for diagnosis, evaluation and effective treatment of alcoholism or drug abuse;
- Provides all medical detoxification services necessary to its effective treatment program;
- Provides, or has a written transfer agreement with a hospital to provide any other required medical services;
- Provides all normal infirmary-level medical services required during the treatment program on a 24-hour daily basis, whether or not they are related to the alcoholism or drug abuse;
- Is always supervised by a staff of physicians and provides skilled nursing services by licensed personnel under the direction of a full-time registered graduate nurse;
- Meets the licensing standards required by the jurisdiction in which it is located; and
- Prepares and maintains a written treatment plan for each of the patients based on a diagnostic assessment of the patient’s medical, psychological and social needs. (Documentation is required to attest that a physician supervises the treatment plan.)

Limitations to the alcohol and substance abuse benefit are as follows:

- The Fund will not make payment for any treatment that is mandated by a court or federal
agency because the individual attempted to commit, or there was a commission of, a misdemeanor or felony or participation in a public disturbance or riot.

- If the individual leaves an inpatient program against the medical advice of a physician, the Welfare Fund will not make any payment for the services that were provided. Consequently, the patient will be responsible for the total amount of the bill.

- Any services rendered prior to the Fund’s written approval or not coordinated by the Fund will not be paid by the Fund.

**Outpatient care.** Prior approval is necessary before the Fund can make payment for this benefit. Deductible applies.

Letters of medical necessity must be renewed annually. Therefore, if you are receiving ongoing treatments for substance abuse from a prior year to a new calendar year, you will need to submit a new letter of medical necessity from a psychiatrist or psychologist to the Fund prior to treatment each calendar year.

The Fund allows up to a maximum of 36 visits per calendar year for outpatient alcohol and substance abuse treatments, provided by a social worker, a practicing psychologist or a duly licensed psychiatrist.

All outpatient substance abuse visits will be combined with any outpatient visits for mental health treatments. The total combined allowable maximum is 36 visits per calendar year.

The Fund will make payments for services performed only by a psychiatrist, licensed social worker, certified social worker or clinical psychologist, and only after prior written approval from the Fund. Deductible applies and this benefit is paid under the participants Major Medical allowance.

Participating providers will be subject to the deductible and payable at 100% of the negotiated rate.

Non-participating providers will be subject to the deductible and paid as follows:

- Psychiatrist, psychologist $100 a visit
- Social worker $70 a visit
- Group therapy $45 a visit
- Family therapy $45 a visit

No payment will be made for Intensive Psychiatric Rehabilitation Treatment (IPRT) or Intensive Outpatient Treatment (IOT).

**Supplemental Medical Health Benefit**

Prior approval is necessary before the Fund can make payment for this benefit. You will be required to forward to the Fund for review the facility or physician’s assessment of medical necessity along with the diagnosis and treatment plan. A physician must sign all facility assessments.

The Fund will provide each participant a lifetime supplemental medical health benefit of $10,000 to offset charges associated for the following services:

1. Charges for home health care*, if you:
   - Have not been released from an inpatient hospitalization of three or more days, and/or
Failed to elect to utilize the Home Health Care benefit within seven days of discharge;
- Elected the services of a non-par and/or non-state certified home health care agency.

2. Synagis injections

3. Private duty nurse benefit; and

4. Infertility benefit not to exceed $5,000.00 per person.

All charges for the aforementioned services will be combined not to exceed a maximum lifetime allowance of $10,000 per participant. The Deductible applies and this benefit is paid under the participant’s lifetime Major Medical allowance.

* The Fund will only make payments for services prescribed by your physician that are performed by a registered graduate nurse, licensed practical nurse, or a certified home health aide.

For nursing services performed by a participating provider, the Fund will pay according to the negotiated rate for the one benefit.

For nursing services performed by a non-participating provider, the Fund will pay 80% of the Fund’s usual, customary and reasonable fee schedule for the one benefit.

Services provided by nurse’s aides are not covered.

Surgical Benefits

Surgeons

For surgeons that participate within the network, the deductible applies. The Fund will pay up to 100% of the negotiated rate for the surgery.

For surgeons that do not participate, the deductible applies. The Fund will pay 80% of the Fund’s usual, customary and reasonable fee schedule.

When multiple surgical procedures are performed through the same incision during the same operation, the Fund only reimburses for one procedure—the one with the highest allowance.

If two or more separate incisions are required at two or more different sites, reimbursement will occur at the allowed amount for the procedure with the highest allowance and at 50% of the allowed amount for the other procedure.

Most hospitals, clinics and freestanding medical facilities contract with independent surgeons, physicians and other medical professionals. These individuals are independent contractors and not on these facilities’ payrolls. Therefore, do not assume that all the medical providers assisting you during your inpatient or outpatient surgery participate in the network.

Speak to your surgeon about utilizing only participating medical providers whenever he or she enlists the services of other medical professionals such as assistant surgeons, anesthesiologists, co-surgeons, laboratory technicians, pathologists, radiologists, etc.
Payment for post-operative visits and consultations conducted within 90 days of your surgery are inclusive in the payment made by the plan to the surgeon.

For information concerning assistant surgeon benefits and co-surgeon benefits, please refer to the sections of this book entitled “Assistant Surgeons” and “Co-Surgeons.”

**Facilities**

Facility charges or fees incurred when the participant has surgery in a participating network facility will be paid at 100% of the negotiated rate.

Facility charges for non-participating surgical centers or non-participating facilities are not covered under the Plan.

**Synagis Injections**

Prior approval is required before the Fund can make payment for this benefit. Deductible applies. The Fund will not make payment toward any services that are rendered prior to the Fund’s written approval.

This benefit is provided under the Fund’s supplemental medical health benefit. All charges for synagis injections will be combined with the participant’s supplemental medical health benefit not to exceed a maximum lifetime allowance of $10,000 per participant.

Services prescribed by your physician that are performed by participating provider will be paid at 100% of the negotiated rate not to exceed the limits previous described.

The Fund will make payments for services prescribed by your physician that are performed by a non-participating provider, at 80% of the Fund’s usual, customary and reasonable fee schedule not to exceed the limits outlined previously.

**Uniformed Services Employment and Reemployment Rights Act of 1994**

If you stop working to enter the military service, you must notify the Welfare Fund in order for the Fund to properly coordinate with any other insurance that you may have or be entitled to receive.

Under the Federal Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994, employers must grant unpaid military leave and continue to subsidize health care coverage for up to 31 days. If you go into active military service, you can continue medical and dental coverage during that period up to 31 days. If your active military service extends beyond 31 days, you may be able to continue your coverage at your own expense for up to 24 months. In addition, your dependents may be eligible for health coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C & 15D will coordinate coverage with CHAMPUS.

When you are discharged from active military duty, your full eligibility will be reinstated on the day
you return to work with a contributing employer and are performing unit work, provided you return to work within:

1. 90 days from the date of discharge if the period of service was more than 180 days; or

2. 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or

3. At the beginning of the first full regularly scheduled working period on the first calendar day following discharge, plus travel time and additional eight hours, if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active military duty, these time limits are extended for up to 2 years.

All of the rights granted by the Uniformed Services Employment and Reemployment Rights Act of 1994 are dependent on uniformed services that end honorably. Separation from the uniformed services that is dishonorable or based on bad conduct, on grounds less than honorable, AWOL, or ending in conviction under court martial, would disqualify a service member from any of the rights under the law.

Usual, Customary and Reasonable Charges

The Plan pays benefits only to the extent that they are Usual, Customary and Reasonable (UCR). In general, this is the amount providers frequently accept as payment for the same service or procedure in your geographical area.

The Fund is the sole determiner of UCR. It determines the usual, customary and reasonable acceptance fees based on data obtained from sources, such as MEDICODE, HIAA and other schedules for relevant zip code areas where the service is being provided.

A charge is considered to be:

1. Usual if it is the fee accepted by a majority of providers for a given service, supply, medication or piece of equipment;

2. Customary if it is the fee accepted by the majority of providers within the same general geographical area for similar care; and

3. Reasonable if the fee accepted is based on the nature and severity of the condition being treated.

Should you require surgery, it is recommended that you ask your Physician to submit the surgical procedure codes and his or her fee to the fund Office in advance of the surgery. The Fund Office will then advise you if the Physician’s fee is greater than the usual, customary and reasonable accepted fee. This way you are aware of any amounts that exceed the usual, customary and reasonable accepted fee amounts for which you will be held responsible.

Remember, most payments for services and procedures are paid at a percentile of the UCR and some services are paid at a flat rate, regardless of network affiliation. So you will want to review the sections of this book that refer to the services you seek. And you will also want to take that into consideration these facts when negotiating with your medical provider.
Varicose Veins

Prior authorization is necessary for sclerotherapy or varicose vein therapy or surgery.

The Fund maintains a lifetime limit for sclerotherapy benefits of $1,440 for unilateral (one leg) and $2,160 for bilateral (both legs). Deductible applies.

Payment to participating providers will be subject to the deductible and payable up to 100% of the negotiated rate up to the Funds lifetime allowance.

Payment to non-participating provider charges will be subject to the deductible and payable at 80% of the Funds usual, customary and reasonable fee schedule up to the Funds lifetime allowance.

Payments will accumulate toward the participant’s lifetime major medical allowance.

Veterans Benefits

Many participants neglect to take advantage of the benefits that they earned for their time spent in service. If you are a veteran who served in the active military, naval or air services including the US Army, Navy, Air Force, Marines, Coast Guard, as well as other categories of services, such as the US merchant marines, you will want to consider the benefits you are entitled to receive when considering your long term medical care benefits.

What am I entitled to receive?

Veterans are eligible to receive a wide range of medical benefits such as primary healthcare, preventive services, diagnosis and treatment, surgery, mental healthcare and substance abuse treatment, home healthcare, hospice and palliative care, nursing home care, emergency care, and pharmaceuticals, as well as financial aid for help with basic daily activities such as bathing dressing, and eating.

How do I go about enrolling for these benefits?

To enroll, you must apply at any veterans’ benefits office or VA healthcare facility. Upon enrollment, you will be placed into one of seven priority groups, based on military service and disability.

To apply for non-service related benefits, you must submit the following:

- Discharge Certificate
- Your latest available social security income letter, or if applicable the social security award letter.
- DD Form 214
- Supporting medical assessment or medical statement
- ACLF letter
- Marriage and / or birth certificates if benefits are for a spouse and / or children
The VA also has an income component and eligible veterans can receive an 80-percent reduction in co-payment rates. Generally, your assets must fall under $80,000.00 for eligibility. However, unreimbursed medical expenses may be used to reduce your income for eligibility purposes.

**How do I coordinate these benefits with those that I am entitled to receive from the Welfare Fund?**

If you have VA benefits and while you are covered under this plan, the VA will bill the Welfare Fund directly for the services you receive while under their care. The Welfare Fund will adjudicate your VA claims according to the provisions according to your eligibility status as an active, retired member without Medicare benefits or a retired participant with Medicare benefits.

In order to facilitate the quick processing of your VA claims, please make sure that the VA has a copy of your most recent medical identification card on file.

**Vision Benefits**

Eye care is an important part of your overall health. The Trustees recognize this and, as a result, provide Vision Benefits for active participants and their eligible dependents.

There is no annual deductible associated with the vision benefit.

The vision benefit allowance covers charges for an eye examination, contact lenses and/or eyeglasses (lenses and frames) if an optometrist or an optician dispenses the eyeglasses. A maximum allowance up to the amounts shown below will be paid once every calendar year for each participant.

- Examination by an optician (OD), or optometrist* $20
- Single vision lenses $50
- Bifocal lenses $60
- Trifocal lenses $75
- Contact lenses $75
- Frames $25

The combined maximum allowable for all lenses is $75 per calendar year.

*If an ophthalmologist performs the exam for a medical diagnosis, the Fund will pay in accordance to the physician benefit outlined within this book.

Since the fund covers eligible expenses only up to a set amount, it is to your benefit to shop for the most cost-effective services and materials. Many vision providers offer coupons for free exams if you purchase a set of lenses and frames; others run seasonal sales.

Additionally, the Welfare Fund has established several relationships with opticians and optical providers in the metropolitan New York area and certain other areas throughout the nation. As such, the Fund has been able to enhance the aforementioned benefits in a manner that can reduce your out-of-pocket cost to zero. For a listing of these providers and the enhanced benefits, please contact the Welfare Fund Office at 212-255-7657 or go online to benefitfunds.iuoe15.org.
Optical Forms should be mailed to:

IUOE Local 15 Welfare Fund
265 West 14th Street - Room 500
New York, NY 10011
ATTN: Optical

Vision Benefit Exclusion and Limitations

You should be aware that some items of vision care are not covered by the Plan. In addition to any item listed in the exclusions and limitations section of the summary plan description, vision benefits are not paid for the following expenses:

1. Services, including:
   a. Eye exams required by an employer.
   b. Eye exercises, including remedial reading exercises.
   c. Orthoptics or visual training.
   d. Refractions
   e. Services/supplies furnished by other than an Optician, Optometrist, or Ophthalmologist.

2. Supplies, including:
   a. Aniseikonic lenses (for binocular vision)
   b. Non-prescription lenses
   c. Non-prescription sunglasses
   d. Subnormal vision aids.

3. Treatment, care, services, or supplies incurred after eligibility for coverage ceases, except when lenses and frames are ordered before coverage ended will be covered if they are delivered within 31 days.

Website – benefitfunds.iuoe15.org

Making informed decisions about your medical care starts with finding helpful information. The Funds website makes that a snap.

Benefitfunds.iuoe15.org is your secure source for personalized, easy-to-use health and benefits information available at any time of the day or night. It delivers the resources you need to manage your care.

Use this site to:
   • Check claim status.
   • Locate In-network providers.
   • Download and print out forms.
   • Check on hospital safety information from the Leapfrog Group.
   • Look for updates to the Plan.

Remember, making better health care decisions is easier when you are an informed consumer.

Checking Your Claims

In order to check your claims on line you must follow the steps outlined below. It takes about ten
minutes to complete but after that you will be able to check your claims directly on a secure, confidential site.

Steps for self-registration to check your medical claims on line:
1. Type into your web browser benefitfunds.iuoe15.org.
2. Click on the section titled “Medical Claims and Eligibility”.
3. At the first screen click on Register User.
4. Under Main Menu click on Member Self-Registration.
5. At the User Registration screen complete the following:
   a) Site ID – use the drop down window to select prod 14.
   b) Group – key in LOCAL15 (Please note that LOCAL15 is entered in caps and that there is no space between the word LOCAL and the number 15.)
   c) Member ID – key in you member ID number. (This is the ID number displayed on the front of your most recent Welfare Fund Insurance Card)
   d) Birth Date – key in your date of birth (you may use the calendar to select)
   e) Click Find. (Note: You do not need a password at this stage of the initial set up.)
6. The system will return a List of eligible dependents (if any) – click on your name
7. At the Member Self-Registration screen complete all fields with an asterisk (*)
   a) User ID – Enter a user id for
   b) Password – Enter a password for yourself that you want use when logging into the system. Passwords are case sensitive and can be 1 to 25 characters. (Must be at least 6 alpha or numeric characters)
   c) Question – Use this field to enter a question you will be asked to answer if you forget your password and need to have it reset.
   d) Response – Enter the answer to the Question you entered in the previous step. By entering in a question and providing the response, you help ensure that you will be the only one with access to your password.
   e) Click Submit Form.

A confirmation message will display once the registration is completed.

You are now able to login.

Click on User Guide for help using this system.

Reset Password
1. Click on Register User
2. Click on Reset Password
3. At the Reset Password screen complete all fields with an asterisk (*)
4. Click on Display Question field on the right side of screen
   a) Enter your User ID.
      (If you forgot your User ID, you must register again)
   b) Click Display Question to display the question you entered when you originally registered.
   c) Select your User ID from list and the question originally entered.
   d) Enter in your response to the Question in Section 2.
   e) Enter your New Password in Section 3.
f) Re-enter New Password to confirm new password.
g) Click Submit Form.
h) You should get the message ‘your password has been re-set. Thank you’
i) Click ‘Close’
j) Click ‘Log Off’

You are now able to login back in with your new password

User ID reminder:
If you forget your User ID:
1. Use the Member Self-Registration option.
2. Complete the Site ID, Group #, SSN and date of birth.
3. A message will display indicating the User ID you had used when originally registered similar to:

   900095 - You have already registered under the 
   USERID: TERRYTEST (TERRYTEST will be the User ID)

You will then be able to use the Reset Password option in the event you need to reset your password. Review the steps under Reset Password.

Weekly Loss of Time Benefits

New York. For an active member, working for an employer whose headquarters are located in the state of New York, a weekly loss of time benefit will be provided to you on the first day of disability due to an accident and on the sixth consecutive business day of disability due to an illness.

New Jersey. For an active member, working for an employer whose headquarters are located in the state of New Jersey, a weekly loss of time benefit will be provided to you on first day of disability due to an accident or the eighth day of disability due to an illness. After you have received disability payments for three consecutive weeks, the State of New Jersey Disability Benefits Law allows you to receive payment for the first seven days of disability.

Non-duplication of benefits provision under New Jersey Temporary Disability Benefits Law:
The New Jersey Temporary Disability Benefits Law prohibits the payment of disability benefits:

- For any period during which benefits are paid or are payable under any unemployment compensation or similar law, or under any disability or cash sickness benefit or similar law of the State or of any other State or Federal government.

- However, if disability benefits are paid or payable to you under the disability benefit law of another State, or under the Federal maritime law, you may still be eligible for New Jersey benefits. In this circumstance, your weekly benefit rate would be reduced by the amount paid concurrently under the other State or maritime law.

- For any period during which workers’ compensation benefits are paid or payable, other than for permanent partial or permanent total disability previously incurred.
Temporary disability benefits are reduced by the amount paid concurrently under any governmental or private retirement, pension or permanent disability benefit or allowance program to which a worker’s most recent employer contributed on his/her behalf. However, please note that Social Security Retirement Benefits do not reduce State Plan temporary disability benefits.

Please contact the State of New Jersey Department of Labor and Workforce Department, P.O. Box 957, Trenton, New Jersey 08625 for more information regarding non-duplication of benefits provisions under the New Jersey Temporary Disability Benefits Law.

**Benefit description.**

The number of periods of disability during any one year is unlimited. A period of disability means the entire period of time during which you are continuously and totally unable to perform the duties of your employment, except that two periods of disability due to the same or related cause or condition and separated by a period of not more than 14 days, will be considered as one continuous period of disability, provided you have earned wages during such 14-day period with the employer who was your last employer immediately preceding the first period of disability.

Your eligibility for weekly loss of time benefits will terminate on the last day of the month following the month in which you were last employed. If you fail to file within this time, and you remain unemployed, you should file for benefits with your state workers’ compensation board. New York residents should file form DB-300.

If your claim for compensation for temporary disability under New York’s workers’ compensation law is contested, and thereby delayed, and you are otherwise eligible for benefits under the Plan, you will be paid the benefits provided by the Plan until and unless you receive temporary disability compensation under New York’s workers’ compensation law. To obtain these benefits you must submit a C-7 form.

In the event that workers’ compensation benefits, other than benefits for permanent partial or permanent total disability previously incurred, are subsequently awarded for weeks for which you received disability benefits under the Plan, the Plan will be entitled to be subrogated to your rights in such award to the extent of the amount of disability payments made under the Plan.

If your workers’ compensation claim has been settled in an amount less than that to which you would otherwise be entitled as disability benefits under the Plan for the same illness or injury, you will be entitled to disability benefits from the Plan for the period of disability, reduced by the amount of your workers’ compensation settlement.

Disability benefits otherwise required under the Plan will be reduced by the amount paid concurrently under any governmental or private retirement, pension or permanent disability benefit or allowance program to which your most recent employer contributed on your behalf.

You will be required to submit to the Fund a copy of your weekly paycheck when you elect for disability benefits.

**Proof of an existing or continuing disability or total disability.** The Board of Trustees has the right to require, from time to time and as often as it determines reasonably necessary, satisfactory proof of any status or condition of a covered participant claiming benefits under the Plan.

In addition, the Board of Trustees has the right to require, from time to time and as often as it determines reasonably necessary, an examination, at the expense of the Fund, by a physician...
selected by the Trustees for proof of an existing or continuing disability or total disability. Failure to provide proof satisfactory to the Board of Trustees will result in disqualification as a covered participant under the Plan or denial of the claim for a benefit.

With regard to the Plan, it is important to remember that no payment will be made for the following:

- In New York, for the first 5 consecutive business days of each period of disability caused by an illness.
- In New Jersey, for the first 7 consecutive business days of each period of disability caused by an illness if disabled for less than 3 weeks.
- For more than 26 weeks during a period of 52 consecutive calendar weeks or during any one period of disability.
- No benefits will be paid unless the disability form is completed in its entirety and signed by a physician.
- Benefits will cease upon the participant failing to provide the Welfare Fund with a requested recertification of the disability.
- Benefits will cease upon your failing to adhere to the Fund’s request to be examined by a physician of the Fund’s choosing to recertify your continued disability.
- For any period for which you are subject to suspension or disqualification of the accumulation of unemployment insurance benefit rights, or would be subject if you were eligible for such benefit rights, except for ineligibility resulting from your disability;
- In New Jersey, for any period of disability which did not commence while you were a “covered individual,” i.e., a person who is in “employment” as defined by the New Jersey Unemployment Compensation Law, for which you are entitled to remuneration from an employer covered by such law, or who has been out of such employment for less than 2 weeks;
- For any disability due to any act of war, declared or undeclared;
- For any disability commencing before you become eligible for benefits under the Plan, but this shall not preclude benefits for recurrence of a disability commencing prior to your eligibility;
- For any disability occasioned by the willful intention to bring about injury to or sickness upon yourself or another, or resulting from any injury or sickness sustained in your perpetration of an illegal act;
- For any day of disability during which you performed work for remuneration or profit;
- For any period of disability during which you are not under the care of a duly registered and licensed physician, chiropractor, dentist or psychologist.
- For any day of disability for which you are entitled to receive from your employer, or from a Fund to which your employer has contributed, remuneration or maintenance in an amount equal to or greater than that to which you would be entitled under the Plan; but any voluntary contribution or aid which an employer may make to you or any supplementary benefit paid to you pursuant to the provisions of a collective bargaining agreement or from a trust fund to which contributions are made pursuant to the provisions of a collective bargaining agreement will not be considered as continued remuneration or maintenance for this purpose;
- For any week for which payments are received under the unemployment insurance law or similar law of the State of New York or of any other state of the United States;
- For any period for which benefits, compensation or other allowances (other than workers’ compensation benefits) for a permanent partial disability occurring prior to the disability for which benefits are claimed under the Plan, and paid or payable under the New York workers’
compensation law or any other workers’ compensation act, occupational disease act or similar law; or under any employers’ liability act or similar law; under any other temporary disability or cash sickness benefits act or similar law; under the volunteer firemen’s benefit law; under section 688, title 46, United States code; under the Federal Employers Liability Act; or under the maritime doctrine of maintenance, wages and cure;

- For a weekly benefit amount which, together with any among that you receive or are entitled to receive for the same period or any part of such period as a permanent disability benefit or annuity under any governmental system or program (except under a veteran’s disability program) or under any permanent disability policy or program of an employer for whom you have performed services, would, if apportioned to weekly periods, exceed your weekly benefit amount under the Plan provided, however, that there will be no offset against the benefits under the Plan if the claim for disability benefits is based on a disability other than the permanent disability for which the permanent disability benefit or annuity was granted.

- If you are receiving wages or salary; or
- If any information on the disability form is missing, or incomplete; or
- If any requested supporting documentation is not supplied, is missing, or is incomplete.

The disability benefit is taxable under the tax codes of the Internal Revenue Service. Consequently, the member will receive Form 1099R from the Welfare Fund for these monies.

It is the responsibility of the participant to notify the Fund Office of the correct date that he or she returned to work. Such notification should take place immediately upon reemployment.

Additionally, if you are disabled and unable to work, be sure the Physician fills out the complete “Attending Physician’s Statement.” The physician should be as specific as possible about when you will be able to return to work; indefinite is too vague an answer, The Fund needs this information to know when your disability began and when it is expected to end.

The Fund will seek reimbursement, interest, and any legal expense associated with the collection of any disability payment that is received by the participant under false pretenses.

Disability benefits for you can terminate at any time there is a misrepresentation on any of the disability forms or if you allow a fraudulent claim to be filed.

Facsimile (faxed) copies of disability forms will not be accepted.

To apply for a weekly loss of time, call the Welfare Fund Office at (212) 255-7657 for a disability claim form.

Welfare Insurance Card

Your medical identification card has been specifically designed. The unique use of a four-sided card containing more pertinent, carefully placed information, as well as user-friendly icons, makes this document not only a medical identification card but a compact resource that address most of the standard questions surrounding the basic plan design of your benefits.

Two medical identification cards are issued to every policyholder. One card is to be kept on person and the other card is to be given to the policyholder’s spouse or placed away in a safe, secure place where it can be located quickly and easily.
Participants are reminded that possession of the medical insurance identification card does not guarantee coverage.

Eligible participants seeking a medical identification card or policyholders wishing to get additional cards or to replace a lost or stolen card may request a card by calling member services at 212-255-7657 or by requesting the card through the Welfare Fund’s website benefitfuunds.iuoel5.org.

Eligible participants and eligible dependents should present their card when requesting any type of covered healthcare service and request that the provider make a copy of all four sides of their medical identification card and to place it in their file.

Treat each card carefully. Carry it with you at all times or keep it in a safe place when not needed.

If you suspect unauthorized use of your card or if your card is lost or stolen, it is your responsibility to notify the Fund Office at (212) 255-7657.

Following is the information included on the identification card:

**Front Side**
- ID number.
- Name of the Policyholder.
- Insurance Provider Name.
- Group number.
- Effective date.
- Participating Provider Network.

**Inside Left**
- Medical Deductible and Co-payment Information.
- List of services that require pre-certification / prior approval.
- Prior Approval fax number.

**Inside Right**
- Disclaimer.
- Contact information for eligibility, benefits, and payment status.
- Contact information for participating provider search and provider status.
- Identification number for the electronic filing of claims.
- Address for the filing of paper claims.

**Back Side**
- Affiliated pharmaceutical network logo.
- Pharmaceutical Provider.
- Pharmaceutical Plan Code.
- Pharmaceutical Group Code.
- Insured ID number.
- Pharmaceutical Deductible information.
- Pharmaceutical phone inquiries number.

Participants are reminded that after any medical service or completed medical procedure, they should request a copy of the claim to review that the procedures being charged were indeed performed, and to make sure that the medical provider recorded your insurance information correctly.
Well Baby Care & Well Child Care

Well baby care and well child care, which consist of routine physical examinations including vision screenings (no refractions), hearing screenings, immunizations and boosters as required by the State of New York, developmental assessment*, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics will be covered.

*Please note that the word “assessment” is used purposely and specifically. Ongoing treatment for developmental conditions are not covered under the Plan.

Participating provider charges for covered services are subject to the deductible and will be payable at 100% of the negotiated rate.

Non-participating provider charges for covered services will be subject to the deductible and payable at 80% of the Fund’s usual, customary and reasonable fee schedule.

Wigs

When in the course of ongoing chemo, radiation therapy, or alopecia areata, the Fund will allow up to $350 toward an annual purchase of a wig. The deductible applies and prior approval is required regardless whether the participant is utilizing a participating network provider or not.

Work & Family Benefits Referral Program

As a participant of this Plan you have access to this unique Program. And, unlike most of the other benefits offered through the Welfare Fund, you do not have to become ill or disabled to access this exceptional benefit.

The Work & Family Benefits (WFB) program is a free, yet exclusive referral program designed to assist you whenever “work-life” concerns or experiences happen in your life or your family’s life.

What are “work-life” concerns or experiences? “Work-life” concerns are recognized as situations that occur in each of our lives that need immediate attention, and require a solution or information that cannot be provided by or through the other benefits outlined within this book.

How does this referral program work? The Work & Family Benefits, Inc. provides you and your family with personalized consultation and referral services whenever “life happens.” Simply call 800-328-4071, send an e-mail to info@wfbbenefits.com or visit the Web site at www.wfbbenefits.com. The WFB will try to help you find real solutions for those areas in your life that you are not an expert on, or the areas or situations where you just need assistance.

What are some examples of “work-life” scenarios? Some “work-life” scenarios in which the Work & Family Benefit referral program can assist you are:

- Adoption
- Assisted living
- Before and after-school child care
- Caregiver support groups
- Assisted devices for daily living
- Back-up child care
- Camps
- Child care
Whether you are experiencing any of the aforementioned situations or if you are experiencing some other “work-life” situation, the knowledgeable counselors at Work & Family Benefits are available for consultation, information and referrals. Do not hesitate to call 800-328-4071 or visit online at www.wfbenefits.com if you should require assistance with a “work-life” scenario.

This referral program is provided to you free. The referral service is confidential and personalized to your needs.

Because of the confidentiality of this program, unless you specifically give the Work & Family counselors permission to speak to the Fund about your specific case, and vice versa, the Fund will be unable to attempt to reduce, limit or even in some cases eliminate any out-of-pocket costs that you may incur.

Accordingly, the responsibility to coordinate the Work & Family Benefit service along with any covered health and welfare benefit will remain the responsibility of the participant.

Workers’ Compensation

The Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C & 15D, is not obligated to pay the medical costs of injuries, illnesses, or accidents that occur on the job or develop through the type of work that you do. By law, injuries and diseases that occur as a result of your employment are covered under the employer’s workers’ compensation policy, and are therefore excluded from coverage under the Plan.

If you need to file a claim, you should take the following steps:

1. Report the accident to your supervisor or employer as soon as possible, or at the very maximum within 30 days from the date of the accident.

2. Seek medical treatment for your injuries immediately, and tell the doctor that your injury is job related. Explain to the physician all pain or injuries related to your work, not just the obvious injury. If not, full treatment can be delayed.

3. Note the exact location of your accident.

4. Obtain the names and addresses of all witnesses, if any.
A Workers’ Compensation claim. It is important to understand that reporting an accident to your employer and getting medical care under the employer’s insurance policy is not the same as filing a workers’ compensation claim.

A workers’ compensation claim should be filed if you are interested in providing long-term protection for yourself and your family and to access rights and benefits for compensation and perhaps other medical care not otherwise provided by your employer’s insurance policy. Claims are easy to file, you don’t even need to lose time from work to file a claim.

Types of Compensable Claims

Workers’ compensation claims fall into two general categories:

- Accidental injuries that happen to occur while you are working
- Occupational injuries that are caused by the kind of work you perform

For injuries that involve the head, neck, back and lungs, you may be entitled to lifetime weekly compensation benefit if you are unable to work or suffer a loss in your weekly salary due to these injuries.

For injuries that involve extremities such as the arms, legs, hands, feet, etc., as well as injuries involving your hearing and eyesight, you may be entitled to a monetary award. The award is based upon the permanent nature of your injury. This type of award is known as a “schedule loss of use” award. You can receive a schedule loss of use award even if you have returned to work or have not lost any time from work.

Your beneficiaries can even be awarded in cases where a work-related injury or illness results in death.

What rights do you relinquish by not filing a workers’ compensation claim? By not filing a claim at all, or not filing in a timely manner, you relinquish your rights to reopen your case for up to 18 years from the date of injury or disablement and for medical care as long as you live.

You may further relinquish your rights to receive cash awards for permanent impairments of limbs, hearing or eyesight. You may also relinquish any potential lifetime weekly payment, or monetary compensation and medical treatment.

Do I really need to deal with workers’ compensation? Yes! If you do not bother to file your workers’ compensation claim within 2 years from your date of accident, you may not receive any future benefits or the cash awards.

Two more important reasons to file workers’ compensation claims:

1. Submitting work-related injury and illness claims into the Welfare Fund of the IUOE, Local 15, 15A, 15C & 15D, is not only incorrect, but it may also jeopardize your workers’ compensation claim and all those long-term rights and benefits that go with it.

2. Moreover, if your injury or illness forces you to stop working and you have to retire, your future benefits may be affected if you cannot prove that the reason you stopped working was because of this injury or illness, rather than just from your age and years of service. Failure to seek medical care, ask for lighter work, apply for social security disability, or inform your employer you have to retire based on your doctor’s advice, before you actually file for retirement, may jeopardize future payments.
World Trade Center Medical Monitoring Program

Funded through a grant provided by the National Institute for Occupational Safety and Health, the World Trade Center Medical Monitoring Program offers free, long-term, 100% confidential health maintenance for recovery and clean-up workers and volunteers who worked at the World Trade Center site.

This program offers:

1. Thorough Medical Exams: As part of the program, you get a thorough check-up every 18 months, which includes your complete medical and work history, blood tests, urinalysis, breathing tests and an evaluation of any stress-related health issues.

2. Detailed Health Information: After each exam, you get a complete confidential report with your test results. No one sees your information, without your give written permission.

3. Early Detection: It is possible that a WTC-related health problem may develop after many years. If so, catching it early will offer you the most effective and current treatment available.

4. Expert Care: If you have any WTC-related health needs, the World Trade Center Medical Monitoring Program helps you get the best care there is by physicians specifically trained to address WTC-related illnesses. You get the care if you need it, whether or not you have insurance.

5. Benefit Information: If you are entitled to benefits, such as Workers’ Compensation and disability, the World Trade Center Medical Monitoring Program can provide information about them.

Did you know that........

1. Many WTC recovery and clean-up workers and volunteers have reported the subsequent health concerns:
   - High rates of ear, nose, throat and sinus symptoms.
   - Ongoing respiratory or breathing problems.
   - Pulmonary problems.

2. Many physicians initially fail to recognize that the aforementioned symptoms may be the result of recovery and clean up work.

3. Many physicians do not have the specific training, or experience needed to effectively address the health care needs of the 9/11 recoveries and clean-up worker.

4. Regular, periodically scheduled medical exams are one of the most effective steps you can take to ensure your health and wellbeing.

Remember, the best way to protect yourself and your family is to keep track of your health.
Need further incentive to make an appointment? Please consider the following:

A. That your participation in this program will allow physicians to track trends and better understand the health care and treatment needs of rescue and recovery workers. The information gained from the monitoring of thousands of workers will be utilized to provide better treatments for you and future disaster relief workers.

B. That the long-term effects of your recovery and clean-up work are unknown.

C. That some Heroes of 9/11 have already passed away as a result of their exposure to toxic substances.

D. That as a result of their exposure to the toxic substances, some Heroes of 9/11 can no-longer work and are currently suffering physically and monetarily.

Help yourself, and help the other Heroes of September 11th, by making your appointment today. Call toll free 1-888-702-0630 or go online to www.WTCexams.org.

Locations of Participating Centers

- **Manhattan**
  
  Mount Sinai, I.J. Selikoff Center for Occupational & Environmental Medicine
  212-241-1554

- **Manhattan**
  
  Bellevue Hospital Center/NYU Occupational & Environmental Medicine Clinic
  212-562-4572

- **Queens**
  
  Queens College Center for the Biology of Natural Systems
  718-670-4216

- **Long Island (Suffolk and Nassau Countries)**
  
  SUNY Stony Brook/Long Island Occupational & Environmental Health Center
  631-444-6436

- **Outside the New York Metropolitan Area**
  
  Follow-up exams are available at many clinical centers nationwide.
  Call 1-888-702-0630 for details.

Call 1-888-702-0630 or register online at www.WTCexams.org to make your appointment.

Keep informed on the latest services, and support available to you by going on line to www.NYC.gov.
Benefits and Provisions For Pension Members And their Eligible Dependents who are not eligible for Medicare Benefits

Future health and welfare benefits are not guaranteed. As stated at the beginning of this book, the Trustees have no resources available other than the existing funds and the bargained contributions to make benefit payments. Consequently, future health and welfare benefits are not guaranteed and are subject to change at any time.

It is important to note in essence, the healthy working members’ contributions, along with any investment interest income, are used to pay the medical claims of the less fortunate, non-healthy participants and for retiree medical and dental benefits.

BEFITS FOR ELIGIBLE RETIRED MEMBERS AND THEIR ELIGIBLE DEPENDENTS WHO ARE AGE 62 AND NOT ENTITLED TO RECEIVE MEDICARE BENEFITS are generally the same as for active members with some differences noted below:

- Accidental Dismemberment Benefits are not covered.
- Children, 19 years or older are not covered.
- The Death Benefit is $7,000.
- Dental Benefits are paid in accordance with the SCHEDULE OF DENTAL CARE BENEFITS up to a maximum of $600 per person per calendar year.
- Disability benefits are NOT covered.
- Eligibility requirements must be met in order to receive these benefits. Eligibility rules can be found under the section titled “Eligibility” in the previous section of this book.
- Exclusions, exceptions and limitations under the Plan are the same as those for active members.
- Hearing Aids are covered at $850.00 per ear every five calendar years. Fittings, repair and replacement batteries are not covered.
- The Lifetime Major Medical maximum benefit is $50,000 per retired member and eligible dependent.

Important: Participants are reminded of the following:

The following charges were never accumulated against your lifetime major medical allowance:

- Dental claims
- Prescription claims processed under the Rx plan.
- Vision claims
- Facility Charges associated with:
  - A participant’s emergency room visit (provided a true emergency)
  - Inpatient hospital stays as described under the hospitalization benefit section.
  - Inpatient stays for both mental health and substance abuse treatments.
- Ambulatory surgery.
- Acute physical and occupational rehabilitation after inpatient hospital stay.
- 200 Lifetime home health care visits after Hospital Stay.
- Dialysis.
- Chemotherapy performed in a hospital.
- Radiation therapy performed in a hospital.

Very Important – Participants are further reminded that:

* That their lifetime major medical maximum as an active participant was $125,000, and
* Upon eligibility for the benefits contained within this section, the amount of major medical lifetime benefits utilized while an active participant will be aggregated and subtracted from the lifetime allowance ($125,000.00) to determine your remaining lifetime major medical allowance.
* However, the major medical maximum under this Plan will not exceed $50,000.

Example One: While as an active participant, Sally, utilized $92,500.00 of her lifetime major medical allowance. Upon retirement, she would only have $32,500.00 remaining of her major medical allowance. ($125,000.00 - $92,500.00 = $32,500.00)

Example Two: While as an active participant, Jake utilized $17,982.35 of his lifetime major medical allowance. Upon retirement, he would be eligible for the full $50,000.00 major medical allowance. ($125,000.00 - $17,982.35 = $107,017.65. However, the maximum allowance for retirees is $50,000.00, therefore, Jake has a $50,000.00 major medical allowance)

Example Three: While as an active participant, Ronald utilized $125,000.00 of his lifetime major medical allowance. Upon retirement, Ron would not be entitled to receive any major medical benefits under this plan. However, Ron may be entitled to receive payment toward, certain inpatient hospital facility charges, true-emergency hospital facility charges, and ambulatory hospital facility charges. Additionally he would be able to receive pharmacy benefits under the Rx plan, dental benefits, and the death benefit as explained within this section of this Plan.

To find out more about what constitutes a major medical expense, please refer to the previous section of this book titled “Major Medical”.

- Orthodontia Benefits are not covered.
- Out of network benefits are paid at 75% of the Fund’s usual, customary and reasonable fee schedule.
- Pharmacy Benefits are paid to a maximum of $1000.00 per person in a calendar year after the $25.00 deductible has been met. Prescriptions are reimbursed at 80% of the balance of the cost of the prescription or refill.

Note: Some retirees have reported that they have reduced the out of pocket costs associated with the purchase of their medications by:

1. Purchasing generic medications whenever possible, and
2. Utilizing mail order services, and / or on line services, and
3. Utilizing their VA benefits, (if applicable) and
4. Purchasing their medications through co-operative organizations or associations that offer discounts, and
5. Purchasing their medications directly from the manufacturer, and  
6. Applied for a manufacture's testing program or grant program for their medications, and  
7. Purchasing their medications through reliable and reputable distributors outside the boarders of the United States.  
   - Vision benefits are NOT covered.

Schedule of Dental Care Benefits
(Services not contained within the listed schedule of benefits will not be covered under this plan)

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>MAXIMUM ALLOWANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each person in the family, the combined maximum allowance for dental in a calendar year</td>
<td>$600</td>
</tr>
<tr>
<td>The maximum number of examinations or cleanings per calendar year</td>
<td>1</td>
</tr>
<tr>
<td>Examinations (includes a charting of all dental defects)</td>
<td>Up to $40</td>
</tr>
<tr>
<td>X-ray allowance</td>
<td>Up to $20, with a maximum number of 4 X-rays per calendar year</td>
</tr>
<tr>
<td>Annual cleaning and scaling of teeth</td>
<td>Up to $30</td>
</tr>
<tr>
<td><strong>Fillings (silver amalgam, synthetic acrylics) per tooth</strong></td>
<td></td>
</tr>
<tr>
<td>Single surface</td>
<td>Up to $26</td>
</tr>
<tr>
<td>Two surfaces</td>
<td>Up to $30</td>
</tr>
<tr>
<td>Three surfaces</td>
<td>Up to $36</td>
</tr>
<tr>
<td>Four surfaces</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Extractions, each tooth</td>
<td>Up to $20</td>
</tr>
<tr>
<td>Root canal, each canal</td>
<td>Up to $70</td>
</tr>
<tr>
<td>Periodontal, each quadrant</td>
<td>Up to $16 per year</td>
</tr>
<tr>
<td>Porcelain/gold inlays, each tooth</td>
<td>Up to $80</td>
</tr>
<tr>
<td>Porcelain veneer laminate</td>
<td>Up to $36</td>
</tr>
<tr>
<td>Caps, crowns, jackets, each tooth</td>
<td>Up to $190</td>
</tr>
<tr>
<td>Post and Core</td>
<td>Up to $75</td>
</tr>
<tr>
<td>Child’s crowns</td>
<td>Up to $95</td>
</tr>
<tr>
<td>Perio-maintenance</td>
<td>Up to $32 per year</td>
</tr>
</tbody>
</table>
DENTURES

Partial dentures, each tooth  Up to $190, with a maximum of $570 per jaw
Full upper or lower, each denture  Up to $422.50, once every two years

REPAIR OF DENTURES

Reline and addition of new material to tooth  Up to $70 for each procedure
Repair and/or replacement of teeth Up to $50 per tooth, with a maximum of three teeth per repair

ORAL SURGERY

Complex extractions, each tooth (where a flap or sutures are required)  Up to $40
Impaction, each tooth (tooth imbedded in jawbone)  Up to $50
Gingivectomy/Osseous surgery  Up to $100 each quadrant
Removal of cysts, including tooth removal  Up to $50
Trimming of bone  Up to $50 each jaw
Removal of root tip (apicoectomy)  Up to $50 each tip
Anesthesia (for oral surgery only)  Up to $75
Incision and drainage of abscess  Up to $50

ORTHODONTICS

Orthodontics is not covered

Note: Fluoride treatments, dental implants and sealants are not covered under this plan.

The combined maximum allowance for dental work may not exceed $600.00 in any calendar year for each person of the family.

Veterans Benefits

Many participants neglect to take advantage of the benefits that they earned for their time spent in service. If you are a veteran who served in the active military, naval or air services including the US Army, Navy, Air Force, Marines, Coast Guard, as well as other categories of services, such as the US merchant marines, you will want to consider the benefits you are entitled to receive when considering your long term medical care benefits.

What am I entitled to receive?

Veterans are eligible to receive a wide range of medical benefits such as primary healthcare, preventive services, diagnosis and treatment, surgery, mental healthcare and substance abuse
treatment, home healthcare, hospice and palliative care, nursing home care, emergency care, and pharmaceuticals, as well as financial aid for help with basic daily activities such as bathing, dressing, and eating.

How do I go about enrolling for these benefits?

To enroll, you must apply at any veterans’ benefits office or VA healthcare facility. Upon enrollment, you will be placed into one of seven priority groups, based on military service and disability.

To apply for non-service related benefits, you must submit the following:

- Discharge Certificate
- Your latest available social security income letter, or if applicable the social security award letter.
- DD Form 214
- Supporting medical assessment or medical statement
- ACLF letter
- Marriage and/or birth certificates if benefits are for a spouse and/or children

The VA also has an income component and eligible veterans can receive an 80-percent reduction in co-payment rates. Generally, your assets must fall under $80,000.00 for eligibility. However, unreimbursed medical expenses may be used to reduce your income for eligibility purposes.

How do I coordinate these benefits with those that I am entitled to receive from the Welfare Fund?

If you utilize your VA benefits while you are covered under this plan, the VA will bill the Welfare Fund directly for the services they rendered. The Welfare Fund will adjudicate your VA claims according to the benefits you would be entitled to receive as an retired participant without Medicare benefits.

In order to facilitate the quick processing of your VA claims, please make sure that the VA has a copy of your most recent medical identification card on file.
Benefits and Provisions for Pension Members and their eligible Dependents, Who Are Eligible for Medicare

Future health and welfare benefits are not guaranteed. As stated at the beginning of this book, the Trustees have no resources available other than the existing funds and the bargained contributions to make benefit payments. Consequently, future health and welfare benefits are not guaranteed and are subject to change at any time.

It is important to note that the healthy working members’ contributions, along with any investment interest income, are used to pay the medical claims of the less fortunate, non-healthy participants and for retiree medical and dental benefits.

Acupuncture

This benefit is available for eligible members only.

The Fund will allow up to 16 visits per calendar year for services performed by a medical doctor, LAC (Licensed Acupuncturist), or DOM (Doctor of Osteopathic Medicine) only. Benefits are limited to one service per day and will be paid at 20% of the Medicare-approved charge, up to $4.00 per visit.

Ambulance

The Fund will allocate up to a total maximum of $250 per 90-day benefit period of non-facility (Part A Medicare Benefits) related benefits toward ambulance services. Payment will be made at 20% of the Medicare-approved charge. Ambulette services are not covered.

Anesthesia

Benefits are payable in connection with a surgery when anesthesia is administered by a doctor other than the operating surgeon, his or her assistant or an employee of the hospital or certified nurse anesthesiologist.

The Fund will pay 20% of the Medicare approved charge not to exceed $250 per 90-day benefit period of the non-facility (Part A Medicare Benefits) related benefits.

Annual Physical

The Fund has contracted with the Professional Evaluation Medical Group (PEMG) to provide each retired participant with an annual physical and hearing test. Participants must utilize the services of PEMG for the annual physical and hearing test to avail themselves of this benefit.

Please note that although the Professional Evaluation Medical Group (PEMG) has successfully handled numerous physical examinations for Local 15 members and participants, you are not required to utilize their services. Charges and fees associated with an annual physical provided by some other entity other than PEMG will remain the responsibility of the participant.
Assistant Surgeon

Assistant surgeon services are not a covered item under the Plan.

Chemotherapy

The Fund will pay up to $12.00 per visit to a maximum of $240 per 90-day benefit period. Payment will be made at 20% of the Medicare-approved charge up to $12.00.

Claims Processing

An itemized bill and a Medicare Explanation of Benefits (EOB) must be submitted for a claim to be processed by the Fund.

If the provider does not submit your claim for you, it is your responsibility to do so. Participants who do not receive an explanation of benefits within eight weeks of treatment should submit a copy of the claim that they received from the provider at the time service was rendered as well as their Medicare explanation of benefits for said service.

Generally, itemized claims should be filed with the Fund within 90 days of incurring covered charges. Late claims are difficult for the Fund Office to process. Claims not filed within twelve months of the date of service, will not be accepted and will be denied.

An itemized claim or bill should include:

- The policy holder’s name, social security number or medical identification number;
- The patient’s name;
- The Physician’s or facility’s name, address and tax identification number;
- The dates of treatment or purchase;
- Medical CPT/hospital revenue codes, and dental ADA codes.
- The type of services (Physician’s office visit, Hospital, lab tests, etc);
- The charge made for each service;
- The condition (the diagnosis) for which the charge was incurred; and
- If due to an injury, indicate how, when, and where the injury occurred.

Provide all necessary information

Participants are responsible for the information on their claims. All participants should review the charges associated with the services that were provided at the time the treatment is rendered or completed. By doing so, you can avoid unnecessary delays in processing your claims by making sure that all the necessary information is included and correct on your claim.

A main reason for delays in processing of benefits is failure on the part of the providers furnishing supplies or services, and the person filing for benefits, to provide all the information needed to determine benefits.
Failure to supply complete information requires the Fund Office to send a request for additional information. This causes delays in processing your benefits.

Information most often omitted by participants and providers alike, in filing for benefits includes:

- Coverage under other group health plans provided through employment of other family members;
- How, when, and where an accidental injury occurred, and a complete description of the circumstances;
- Diagnosis of the condition for which the patient received treatment;
- The Physician’s tax identification number;
- Correct itemization for charges; and
- Verification of a dependent’s status, if applicable.

Assignment of Benefits

If you want the Fund to pay your medical provider directly, sign the “Assignment of Benefits” portion of the claim form. Then the Fund makes direct payment to the provider and sends you an explanation of benefits (EOB) so you know what was paid.

Please reference the section of this book titled “Coordination of Benefits” to learn more about coordinating these benefits with other benefits you may have through Medicare or another insurance provider.

Chiropractic Expense Benefits

This benefit is available to eligible members only.

The Fund allows up to 24 visits per calendar year and up to 4 X-rays per calendar year.

The Fund will allow only 1 visit per day and will pay up to $4.00 per visit.

The X-ray allowance will be paid at 20% of the Medicare-approved charge not to exceed the $75.00 of the diagnostic testing allowance per calendar year.

Coordination of Benefits - Coverage Under More Than One Plan

If you or an eligible dependent has coverage under two or more health plans, this Funds benefits will be coordinated with the other insurer according to the provisions outlined within the section of this summary plan description book titled “Coordination of Benefits”.

If you or an eligible dependent do have coverage under two or more health plans, be sure to include the name of the other health plan(s) on your claim form.

Additionally, if a participant is covered by Medicare and /or another plan, they must attach a copy of the itemized bill relating to the health service provided and a copy of any explanation of benefits.
(EOB) from the other provider. Both the bill and the EOB must be submitted.

If Medicare is you or your dependents’ primary insurer, ask your provider to bill Medicare for you. When Medicare makes its payment, you will receive an EOB from Medicare.

You must submit a copy of the Medicare EOB, along with an itemized statement from your provider to the Fund so benefits can be coordinated with payment from Medicare.

Please do not forward the itemized statement to the Fund until you have the Medicare EOB. If you do, the Fund Office will send you a letter requesting the Medicare EOB before you file a claim.

**Failure to submit requested information and documentation.**

You have ninety days (90) after you receive the notification requesting additional information to submit said information into the Fund. If the information and/or supporting documentation is not received within this period, the claim will be denied and payment for the service or treatment will remain the responsibility of the participant.

**Co-Surgeons**

Services provided by co-surgeons are not covered.

**Death Benefit**

The Death Benefit is $7,000.00 for eligible members and eligible retired Fund employees only.

**Deductible – Medicare Part A Deductible**

**Inpatient Hospitalization**

The Fund covers the Medicare Part “A” deductible for covered inpatient (hospitalization) services every 60 days for each diagnosis.

**Deductible – Medicare Part B Deductible**

**Outpatient Services**

The Fund covers the Medicare Part “B” calendar year deductible for the following approved outpatient services:

- Emergency room treatment in a hospital
- Ambulatory surgery performed in a hospital
- Diagnostic testing performed in or out of a hospital
- Physician Visits in or out of a hospital
- Surgery in or out of a hospital
- Anesthesia benefits performed in or out of a hospital
Medical Benefits: After satisfaction of the Annual Part B Medicare deductible, benefits are paid subject to Medicare Approved Charges. For detailed explanations of all of the coverages and benefits provided under the Fund’s plan as a supplement to Medicare, see the specific benefit section.

Dental Benefits

Dental Benefits will be paid at 100% of the fee schedule to a maximum of $600.00 per person, per calendar year.

Dental benefits for services performed by a licensed dentist will be paid in accordance with the schedule of dental care benefits listed below.

No benefits will be paid in excess of the amount charged, nor will a licensed dentist be paid any benefit if the patient does not incur an actual charge.

No payment will be made for any amounts for which you are not legally liable in the absence of coverage by the Fund.

Coverage for dental conditions that exist prior to becoming eligible for this benefit will be provided, but no payment will be made for any dental work performed prior to your becoming eligible for this benefit.

Dental work commencing after the termination of coverage by the Fund is not covered.

An ADA claim form must be completed and returned to the Fund Office within 30 days after all dental work is completed.

No payment will be made for accident or illnesses covered by workers’ compensation, nor for treatment received in hospitals, clinics, etc., operated by federal, state, county or municipal agencies.

The specific dental benefits available to you appear on the table below.

Schedule of Dental Care Benefits

(Services not contained within the listed schedule of benefits will not be covered under this plan)

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>MAXIMUM ALLOWANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each person in the family, the combined maximum allowance for dental in a calendar year</td>
<td>$600</td>
</tr>
<tr>
<td>The maximum number of examinations or cleanings per calendar year</td>
<td>1</td>
</tr>
<tr>
<td>Examinations (includes a charting of all dental defects)</td>
<td>Up to $40</td>
</tr>
<tr>
<td>X-ray allowance</td>
<td>Up to $20, with a maximum number of 4 X-rays per calendar year</td>
</tr>
<tr>
<td>Annual cleaning and scaling of teeth</td>
<td>Up to $30</td>
</tr>
</tbody>
</table>
Fillings (silver amalgam, synthetic acrylics) per tooth

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single surface</td>
<td>Up to $26</td>
</tr>
<tr>
<td>Two surfaces</td>
<td>Up to $30</td>
</tr>
<tr>
<td>Three surfaces</td>
<td>Up to $36</td>
</tr>
<tr>
<td>Four surfaces</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Extractions, each tooth</td>
<td>Up to $20</td>
</tr>
<tr>
<td>Root canal, each canal</td>
<td>Up to $70</td>
</tr>
<tr>
<td>Periodontal, each quadrant</td>
<td>Up to $16 per year</td>
</tr>
<tr>
<td>Porcelain/gold inlays, each tooth</td>
<td>Up to $80</td>
</tr>
<tr>
<td>Porcelain veneer laminate</td>
<td>Up to $36</td>
</tr>
<tr>
<td>Caps, crowns, jackets, each tooth</td>
<td>Up to $190</td>
</tr>
<tr>
<td>Post and Core</td>
<td>Up to $75</td>
</tr>
<tr>
<td>Child’s crowns</td>
<td>Up to $95</td>
</tr>
<tr>
<td>Perio- maintenance</td>
<td>Up to $32 per year</td>
</tr>
</tbody>
</table>

DENTURES

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial dentures, each tooth</td>
<td>Up to $190, with a maximum of $570 per jaw</td>
</tr>
<tr>
<td>Full upper or lower, each denture</td>
<td>Up to $422.50, once every two years</td>
</tr>
</tbody>
</table>

REPAIR OF DENTURES

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reline and addition of new material to tooth</td>
<td>Up to $70 per procedure</td>
</tr>
<tr>
<td>Repair and/or replacement of teeth,</td>
<td>Up to $50 per tooth, with a maximum of three teeth per repair</td>
</tr>
</tbody>
</table>

ORAL SURGERY

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex extractions, each tooth (where a flap or sutures are required)</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Impaction, each tooth (tooth imbedded in jawbone)</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Gingivectomy/Osseous surgery</td>
<td>Up to $100 each quadrant</td>
</tr>
<tr>
<td>Removal of cysts, including tooth removal</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Trimming of bone</td>
<td>Up to $50 each jaw</td>
</tr>
<tr>
<td>Removal of root tip (apicoectomy)</td>
<td>Up to $50 each tip</td>
</tr>
<tr>
<td>Anesthesia (for oral surgery only)</td>
<td>Up to $75</td>
</tr>
<tr>
<td>Incision and drainage of abscess</td>
<td>Up to $50</td>
</tr>
</tbody>
</table>

Pension-Medicare PM-6
ORTHODONTICS

Orthodontics are not covered

Note: Fluoride treatments, dental implants and sealants are not covered under this plan.

The combined maximum allowance for dental work may not exceed $600.00 in any calendar year for each person of the family.

Dietician/Nutritionist

This benefit is available to eligible members only.

The Fund will allow up to 4 visits per calendar year for services performed by a licensed dietician. The Fund will pay $4.00 per visit, limited to 1 visit per day.

Diagnostic Testing/X-ray and Lab

The Fund provides benefits for the services necessary for the diagnosis and treatment of a covered medical condition. Services would include, but are not limited to, X-rays, examinations, imaging services such as MRIs and cat scans, radiology imaging, mammographies, laboratory services and other diagnostic services.

The Fund will pay at 20% of the Medicare-approved charge up to $75 maximum per calendar year.

Durable Medical Equipment

Durable medical equipment is not a covered item under this plan.

Electroshock Benefits

The Fund will pay $15 per treatment up to a maximum of $150 per calendar year.

Eligibility

Eligibility requirements for pensioned members who elect normal retirement. If you are receiving a regular pension from the Central Pension Plan of the International Union of Operating Engineers, you and your eligible dependents are entitled to certain Welfare Fund benefits, provided you are over the age of 62 and meet one of the following criteria:

- You have 25 years of pension credits at the time you apply for retirement; or
- You have at least 10 years of vested pension credits and have accumulated at least three of those years of pension credits during the five successive years immediately prior to your date of retirement.
The benefits you and your eligible dependents are entitled to receive can be found in the section of the book entitled “Benefits and Provisions for eligible Pensioned Members who are 62 and older and not entitled to receive Medicare Benefits” or “Benefits and Provisions for Pension Members and their Eligible Dependents who are eligible for Medicare”

**Note:** Retirement is an excellent opportunity to update both your enrollment and beneficiary information as well as complete a new authorized representative form and health care proxy.

**Eligibility requirements for members who elect early retirement.** If you elect for early retirement your coverage will cease with this Plan upon the normal cessation of the benefit period you are covered through at the time of early retirement approval from the Central Pension Fund.

However, provided that you meet the following requirements:

1. You had twenty-five years or more of vested pension credits; and
2. You were covered for medical benefits by this Fund at the time you were approved for an early retirement pension by the Central Pension Fund, and
3. You are 65 years or older, and Medicare eligible.

You would be reinstated into the plan and entitled to receive the benefits that are outlined in the section of the book entitled “Benefits and Provisions for Pension Members and their Eligible Dependents who are Eligible for Medicare Benefits”.

Provided your spouse meets the following criteria:

1. Attains the of 65 or older, and
2. Is Medicare eligible.

He/she would be reinstated into the plan and entitled to receive the benefits that are outlined in the section of the book entitled “Benefits and Provisions for Pension Members and their Eligible Dependents who are Eligible for Medicare Benefits”.

Dependent children, regardless of age will not be reinstated into the plan.

**Note:** If you are electing this provision, please make sure that you update both your enrollment and beneficiary information as well as complete a new authorized representative form and health care proxy.

**Eligibility requirements for members who are awarded a Social Security Disability.** If you are awarded Social Security disability benefit while you are a covered member, you and your eligible dependents are entitled to certain Welfare benefits provided you meet the following criteria:

1. You have 15 years of contributions of at least 1000 hours per year into the Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D.
2. You were covered under this plan at the time you were awarded a Social Security disability, and
3. You were covered under this plan during each benefit period in three of the five successive years immediately prior to the onset date of your disability, and
4. The Central Pension Fund of the International Union of Operating Engineers, in connection with such permanent and total disability, awarded you a disability pension while you were covered under this plan.
Participants wanting to avail themselves of this benefit must submit a copy of their Social Security Disability award to the Plan Administrator. The award must state that the onset of your disability occurred prior to your original termination with the Plan.

The benefits you will be entitled to receive are those that are outlined in the section of the book entitled “Benefits and Provisions for Pension Members and their Eligible Dependents who are not eligible for Medicare Benefits”. The Fund will provide these benefits until such time that you or your eligible dependents become Medicare or Medicaid eligible. At that time the benefits you will be eligible to receive will be those that are outlined in the section of this book titled “Benefits and Provisions for Pension Members and their Eligible Dependents who are eligible for Medicare Benefits”.

**Note:** If you are electing this provision, please make sure that you update both your enrollment and beneficiary information, as well as complete a new authorized representative form and health care proxy.

Entitled to Medicare Benefits who cease to actively work. For Medicare eligible members who have earned enough hours to meet the eligibility requirements for an active member but cease to be actively employed by a contributing employer within the jurisdiction of the I.U.O.E., Local 15, 15A, 15C & 15D, Medicare will be considered your primary insurer and the Welfare Fund your secondary insurer on the date you cease to be actively employed.

**Important:**

1. Participants must notify the Fund of the date that they ceased to be actively employed in writing no later than two weeks after said date, so that the Fund may properly coordinate your benefits with those of Medicare.

2. Participants are reminded that they need to sign up for Medicare Benefits at the earliest time they are eligible in order to maximize the benefits contained within the section of the Book titled “Benefits and Provisions for Pensioned Members and their Eligible Dependents, Who are Entitled to Medicare.”

Please note that the use of the word “entitled” is deliberate as the benefits of a non-actively contributing participant age 65 or older will only be entitled to the benefits outlined within the aforementioned section.

3. Participants that fail to notify the Fund Office or those who knowingly file their claims to the incorrect insurer will be subjected to the Fraud provisions of the Welfare Fund.

4. Participants who are entitled to receive Medicare Benefits are directed to read the provisions (outlined below) contained within the gold section of this booklet titled “Benefits and Provisions for Pensioned Members and their Eligible Dependents, Who are Entitled to Medicare.”
   - Coordination of Benefits, and
   - Eligibility, and
   - Enrollment, and
   - Medicare

**Note:** The rules and plan design of the aforementioned provisions will be strictly adhered to.

**Eligibility for continued coverage for the eligible dependents of a “Retired” deceased member.** As long as the participant had coverage at the time of death, coverage for Welfare Fund benefits will be extended to the surviving spouse, handicapped children and unmarried eligible dependents under the age of 19 for a period of 36 months from the date of death of the participant.

Coverage will be determined in the following manner for any unmarried eligible dependent child of...
a member who at the time of death had retired benefits without Medicare benefits or retired benefits with Medicare benefits:

- Upon attaining the age of 65 or becoming Medicare eligible, whichever is first, the benefits for the surviving spouse will be those that can be found in the section of this book titled "Benefits and Provisions for Pension Members and their Eligible Dependents who are eligible for Medicare Benefits".

- Benefits for unmarried dependents of Retired participants that have not attained the dependent’s 19th birthday will be paid according to the provisions found in the section of this manual titled "Benefits and Provisions for Pension Members and their Eligible Dependents who are not eligible for Medicare Benefits."

Benefits will only be paid for a maximum of 36 months, or until the dependent’s 19th birthday, whichever comes first. Benefits beyond his or her 19th birthday will not be paid.

Note: If you are receiving Health and Welfare benefits as a result of the death of a retired member, you are urged to read the benefit section entitled “House Calls”.

A loss of a love one affects the entire family. Due to grief, there are often causes and effects that go unnoticed until months later.

The Trustees who oversee the Fund Plan understand this and have created the House Call benefit in response.

What is House Call? It is a “check in” service where we may come to you to make sure that you and your family are aware of all services provided by the Welfare Fund to help you through this trying time.

Additionally, if you as the survivor participant need assistance updating your enrollment form, authorized representative form, health care proxy form or beneficiary form, you are encouraged to call the Fund Office.

Getting Married

When you get married, your spouse is automatically eligible for coverage effective as of the date of your marriage. However, no benefits will be processed by the Fund Office until you have provided to the Fund Office a completed enrollment form along with any required supportive documentation or information outlined in the section of this book titled Enrollment.

Please notify the Fund Office as early as possible after your marriage. However, if you do not notify the Fund Office within 30 days of your marriage date, your spouse’s coverage will not begin until the first day of the month after you notify the Fund Office.

Participants who are either getting married or have recently married may wish to update their beneficiary designation under the Plan, as well as complete an authorized representative form and health care proxy. Please contact the Fund Office to request a beneficiary form or login at benefitfunds.iuoe15.org to download a form.

Getting Divorced

If you and your spouse get divorced, your spouse will no longer be eligible for coverage as a dependent under this Plan effective as of the date the divorce is final. However, your spouse may elect to continue coverage under C.O.B.R.A., for up to 36 months. You or your spouse must notify the Fund Office within 60 days of the divorce date for your spouse to obtain C.O.B.R.A., continuation coverage.
In general, once you are divorced, stepchildren from your former marriage are no longer covered under the Plan, but may be eligible for C.O.B.R.A., continuation coverage.

The Fund Office requires you to submit supporting documentation such as a copy of your divorce decree or a copy of any Qualified Domestic relations Order (QDRO) and/or Qualified Medical Child Support Order (QMCSO).

Losing Eligibility

The Welfare Fund is designed to provide benefits for all eligible Participants and their eligible dependents. However, it is possible for you and/or your dependents to lose eligibility for coverage.

You and/or your eligible dependents may lose eligibility if:

1. You or your dependent’s commit a fraudulent act against the Fund.
2. In the event of a divorce, your spouse and stepchildren’s eligibility ends on the date a divorce is final. Your spouse and stepchildren may be eligible to continue coverage by electing COBRA continuation of coverage.
3. There is a written amendment to this summary plan description that affects eligibility.

Change of Eligibility Rules and Benefits

Over time, it may be necessary to change the eligibility rules and the benefits provided by the Health Benefit Fund, including benefits provided to the retirees. The Trustees, at their discretion, have the right to interpret, change, modify or discontinue all or part of the eligibility rules or benefits provided, at any time, by written amendment to this summary plan description.

Whenever policies (such as self-payment contribution rates, benefits provided, etc.) change, you will notified of the changes and copies of the changes will be on file at the Fund Office. If you have any questions about these policies, contact the Fund Office.

Enrollment

Enrollment requirements for benefits under this section of the Plan are identical to the requirements and procedures outlined within the section of the “Benefits and Provisions for Active Working Members and their Eligible Dependents” under “Enrollment”. Please refer to that section of the booklet for information, requirements and procedures.

Gastric Bypass or Bariatric Benefits

Prior approval is necessary before the Fund can make payment for this benefit. Therefore, it will be necessary to mail a letter of medical necessity, along with a complete medical report, in order to determine that surgery is not being performed for any cosmetic reason. A true medical diagnosis is necessary, stating medical condition.

The Fund will allow payment at 20% of the Medicare approved charge up to a maximum of $300 in a 90-day benefit period for this procedure, provided that the procedure is solely used to treat morbid obesity.

The Fund will not make any payment for this surgery if no true life-threatening medical condition exists. Failed diets, lack of eating discipline and/or exercise programs do not constitute medical necessity.
Hearing Aids

Hearing aids are not a covered benefit under this plan.

Hospital Benefits

The Fund will pay for the Medicare deductible of the participant’s first 60 days of hospital confinement.

The Fund will pay $10.00 towards an ambulatory surgery or emergency room visit.

For inpatient hospitalization stays greater than 60 days, but less than 151 days, the Welfare Fund will pay for the per diem co-insurance amount.

The Fund will not make any payment for charges after 151 days of hospital confinement.

The payment for deductibles and co-insurance will be coordinated with the coverage of Medicare Part A benefit periods. Successive stays in one or more hospitals count as one benefit period, unless 60 days or more have elapsed between the date of discharge and the next admission. If 60 days have elapsed since the last discharge, a new hospital stay is counted as the start of a new benefit period.

Per diem co-insurance amounts for inpatient hospital stays will be calculated in accordance with Medicare Part A Hospital Benefits.

The Fund will not duplicate hospital and medical benefits covered under Medicare.

The Fund’s Plan will supplement Medicare Part A and Part B coverage provided that the services rendered are considered a covered benefit under the Fund’s Plan.

PART A

Hospital Benefits: Semi-private room and board and facility services and supplies.

<table>
<thead>
<tr>
<th>Medicare Covers</th>
<th>Fund Covers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1-60: All except the deductible</td>
<td>The deductible</td>
</tr>
<tr>
<td>Day 61-90: All except 25% of the Co-insurance.</td>
<td>The co-insurance amount</td>
</tr>
<tr>
<td>Day 91-150: When using the 60 lifetime reserve days, all except 50% of the co-insurance amount.</td>
<td>The co-insurance amount</td>
</tr>
<tr>
<td>Day 151 and after No coverage after expiration of the 60-day lifetime reserve</td>
<td></td>
</tr>
</tbody>
</table>

Blood:

All but the first 3 pints          The first 3 pints

Hospice Care:

All but very limited co-insurance for outpatient, drugs and inpatient respite care (care must be doctor certified)

Not covered

Home Health Care:

100% of Medicare approved amount for the first 100 days in a spell of illness

Not covered
Deductibles and co-insurance are not covered for inpatient confinements associated with mental health, drug addiction or alcoholism.

The Fund will not provide benefits for any service rejected by Medicare.

Nursing homes, convalescent homes, and institutions used primarily for rest, such as spas or sanitariums, are not considered to be a hospital. No benefits will be provided for services rendered within these institutions.

House Call: Services for Members with Temporary Disability or Other Urgent Family Situations

If you become temporarily disabled – due to physical, emotional or mental health factors – you and your entire family can be affected. The illness of one person in the family has causes and effects that are often unnoticed, but they are factors that impact your family in many different ways.

The Trustees who oversee the Fund Plan understand this and have created the House Call benefit program in response to members’ needs.

What is House Call?

- It’s a “check-in” service, providing one or more telephone calls to you when you are out of work due to temporary disability or other family lifecycle events.

- The purpose of the calls is to make sure that you and your family are aware of all benefits provided by the Welfare Fund to help get your lives back to normal.

- House Call is free and confidential. A counselor calls you to let you know about benefits that exist within the Fund, or outside of the Fund, which may be of value in your particular situation.

What can House Call do for you and your family?

House Call counselors offer information and referrals which can help you and your family during a difficult time, including features of your benefit program that you may not have considered. For example, there are emotional and monetary issues that can come up while you are dealing with physical problems; and there are physical problems that can arise when you are dealing with stress.

The important thing is for you and your family to come through these problems in the best ways possible, and that often means dealing with the situation in more than just one way. And that is what House Call helps you do.

The Fund maintains the right to initiate the House Call program on your behalf when it is considered appropriate or necessary to help you. The decision to use the services that House Call counselors suggest is always up to you.

Not all situations will prompt this program. But always remember, YOU can “check in” with Work and Family Benefits whenever YOU want. You don’t have to wait to get a call – make the call: 1-800-328-4071.

LASIK Benefits

Prior approval is necessary before the Fund can make payment for this benefit. Therefore, it will be necessary to send in a letter of medical necessity along with a complete medical report in order to determine that surgery is not being performed for any cosmetic reason.

Benefits will be paid at 20% of the Medicare-approved charge up to $300 per 90-day benefit period.
The Fund will not make any payment for this surgery if the primary reason the participant wants this procedure is because he or she no longer wants to wear glasses.

No payment will be made for this procedure if glasses or contact lenses can correct the optical condition.

The Fund reserves the right to require a second opinion for any surgical procedure or determination of disability.

**Lithotripsy** (Calcification in bladder or urethra)

The Fund will pay at 20% of the Medicare-approved charge up to $300 per 90-day benefit period, for any one incident.

**Major Medical**

There is no Major Medical for Eligible Members and their dependents.

**Medicare**

Medicare provides health insurance for persons age 65 and over (whether they are retired or working), for persons under age 65 who have been disabled for two or more years, and for persons with end-stage renal disease.

The Fund’s Plan will be the secondary payer for pensioned members and their eligible dependents that are over age 65 and who are eligible to receive Medicare.

The Fund’s Plan will be the secondary payer for persons under age 65 who are entitled to Medicare benefits due to total disability.

Medicare Part A (hospital insurance benefits) is given automatically to persons who are eligible for Social Security retirement benefits at the normal Social Security retirement age.

In order to receive Part B (medical insurance benefits), as well as Part D, persons must elect and enroll to these programs.

The Fund recommends that you contact the Social Security Administration to learn more about Part A, Part B and Part D. Visit the Social Security Administration’s Web site at www.ssa.gov or call your local Social Security Office.

**Medigap Supplemental Reimbursement Program:**

A Medigap insurance policy is an additional insurance policy that Medicare Part A and Part B recipients may purchase from private insurance companies. These policies are designed specifically to supplement Medicare’s Benefits or to fill in the “gaps” in the services and procedures that Medicare does not cover, as well as pick up some additional expenses.

There exist Federal minimum standards for private Medigap policies. These policies have different combinations of benefits, and may vary from one insurance company to another. Participants are encouraged to scrutinize these plans carefully.
In light of the existence of these types of insurance policies, the Trustees recognize that:

- Some retired participants can acquire better benefits through a Medigap insurance program than the benefits offered through this Fund; and
- That many Medigap programs cost additional monies beyond the monies supplied monthly to these private insurers by Medicare; and
- That the benefits offered through this Fund could prevent you from taking full advantage of all the programs and benefits offered through the Medigap program.

As such the Trustees have designed this benefit in order to assist participants with the monthly premium cost of belonging to one of these private Medigap insurance programs.

Any Medicare Part A and Part B participant who wishes to be reimbursed for the fees that may be associated with the Medigap program of their choosing, may enroll into this program. Please contact the Fund Office for a Medigap enrollment form or visit benefitfunds.iuoe15.org to download a form.

IMPORTANT: Participants who wish to enroll into the Medigap supplemental reimbursement program will forfeit all Medical, Hospital, and Dental Benefits under this plan from the date of enrollment.

Enrollment & Un-enrollment Period: Newly eligible Medicare participants may enroll into this program within 60 days from their 65th birthday.

Participants who miss the initial enrollment sixty-day period will be allowed to enroll during this Funds annual enrollment period. This period occurs each calendar year on any business day from November 15th through December 31st. Enrollment forms received after this period will not be considered for this benefit.

Additionally, participants will remain enrolled until they notify the Fund in writing during the enrollment and un-enrollment period of their desire to no longer participate within this program. Written notifications received after this period will not be considered for un-enrollment.

Payment: After enrollment, the Fund will reimburse up to a maximum of $83.00 a month toward your monthly premium. The Funds payment will not exceed the monthly premium. Therefore, if your monthly premium is less than the Funds monthly allowance, the Fund will only pay up to that premium amount.

$$$$$$$$: Participants utilizing a Medigap program that offer a pharmaceutical rider, can instruct this Fund to direct its Medicare Plan D Pharmacy Supplemental Benefit toward offsetting the additional cost of your monthly premium. The fund will reimburse up to $25.00 per month not to exceed $300 per calendar year towards the Medicare Part D monthly premium.

For example, If your Medigap premiums are $138.00 a month, the Welfare Fund will reimburse $83.00 dollars toward the medical portion of the policy, plus $25.00 dollars toward the pharmaceutical portion of the policy, totaling $108.00 dollars a month to offset your monthly premium payment.

Proof: Participants must submit a copy of their premium payments into the Fund Office in New York in order to receive reimbursement. Payments can be submitted monthly or quarterly. Submission of proof of monthly premium payment thirteen months old or greater will not be considered for reimbursement.

Note: Beneficiaries of deceased participants who elected into the Medigap supplemental reimbursement program are eligible to collect a death benefit provided they file within 12 months of the participant’s date of death.

Orthotripsy

The Fund will pay at 20% of the Medicare-approved charge up to $300 per 90-day benefit period, for any one incident.
Outpatient Mental Health Benefits

This benefit is available to eligible members only.

Prior approval is necessary before the Fund can make payment for this benefit. A letter of medical necessity, with diagnosis code must be provided by a psychiatrist or psychologist, prior to treatment.

The Fund allows up to a maximum of 36 visits a year for outpatient mental health treatments provided they are obtained by a social worker, a practicing psychologist or a duly licensed psychiatrist.

All outpatient benefits will be paid as follows:

<table>
<thead>
<tr>
<th></th>
<th>Office Visit</th>
<th>Home Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist, psychologist</td>
<td>$4.00 a visit</td>
<td>$5.00 a visit</td>
</tr>
<tr>
<td>Social worker</td>
<td>$4.00 a visit</td>
<td>$5.00 a visit</td>
</tr>
<tr>
<td>Group therapy</td>
<td>$4.00 a visit</td>
<td>$5.00 a visit</td>
</tr>
<tr>
<td>Family therapy</td>
<td>$4.00 a visit</td>
<td>$5.00 a visit</td>
</tr>
</tbody>
</table>

The maximum benefit for any one illness is $500.

All pharmaceutical management visits must be provided by a medical doctor, a psychiatrist/psychologist, and will be paid at the rates listed above. These visits will count toward the participant’s annual maximum allowable visits.

In order to receive approval, and hence payment for these benefits, the member is required to mail or fax into the Fund prior to that treatment the attending physician’s written description of the present illness, together with a diagnostic code and treatment plan that includes an estimated length of treatment.

No payment will be made for:

- Any treatments or conditions that are not organic.
- Any treatment that is associated with marriage counseling or relationship issues.
- Any treatment that is mandated by a court or federal agency because the individual attempted to commit, or there was a commission of, a misdemeanor or felony or participation in a public disturbance or riot.
- Treatment that is the result of externally induced chemical agents. Rehabilitation programs related to alcoholism and substance abuse are not considered mental health services under this provision.
- Any services that are billed by a hospital or a hospital-affiliated facility, such as a clinic, or attached outpatient medical facility.
- Any service that is rendered by someone other than a social worker, a practicing psychologist or a duly licensed psychiatrist.
- Any other individual with other credentials or a religious or spiritual individual.

Part D Pharmacy Supplemental Benefit Program

Participants are notified that:

1. The Welfare Fund does not offer credible prescription drug coverage. Credible Pension-Medicare
prescription drug coverage is pharmaceutical coverage that is on average at least as good as the Medicare standard prescription drug coverage;

2. As such, participants should join a Medicare Part D Prescription drug plan because upon eligibility for Medicare Part D benefits, they will cease to be eligible for pharmaceutical benefits under the Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D.

Medicare Part D Prescription Drug Coverage is insurance and is available to everyone who is eligible for Medicare benefits. Private companies provide this coverage. You choose the drug plan and pay a monthly premium.

NOTE: The Fund strongly recommends that each eligible Medicare Part D participant enroll into the program of their choice as soon as they are eligible so as to avoid a lapse in coverage, possible out of pocket expenses and/or a financial penalty by The Center of Medicare Services for untimely enrollment.

If you have any questions, please contact the Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D at 265 West 14th Street, New York, NY 10011 or by telephone at (212) 255-7657.

For more information about your options under Medicare prescription drug coverage ...

More detailed information about Medicare plans that offer prescription drug coverage is available through the “Medicare and You” handbook. You will get a copy of the handbook from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

The Trustees have set a provision to offset the cost of the Medicare Part D benefit. The fund will reimburse up to $25.00 per month not to exceed $300 per calendar year towards the Medicare Part D monthly premium.

**Physician Benefits**

**Inpatient Hospital Visits**
The Fund will pay $4.00 per visit up to a maximum of $250 of non-facility related inpatient benefits per illness every 90 days.

**Outpatient Visits**
The Fund will pay for up to 2 visits per day, not to exceed a maximum of $500 per illness every 90 days

**Office Visits:** The Fund will pay up to $4.00 per visit.

**Home Visits:** The Fund will pay up to $5.00 per visit.
Orthotics

Orthotics are not a covered benefit under this plan.

Podiatry

Benefits will be paid at 20% of the Medicare-approved charge up to $300 per 90-day period for any one incident of a surgical procedure performed by a podiatrist.

The Fund will pay up to $4.00 for an office visit not to exceed 20% of the Medicare-approved charge. (Benefit is for Member Only).

Physical/Occupational/Speech Therapy

Physical, Occupational, and Speech therapy is not a covered benefit under this plan.

Radiation Therapy

The Fund will pay up to $12 per visit to a maximum of $240 per 90-day benefit period. Payment will be made at 20% of the Medicare-approved charge up to $12.00.

Respiratory Therapy, Cardiac Therapy, Cognitive Therapy

This benefit is available for eligible members only.

The Fund will pay $4.00 per visit up to a maximum of $500 per 90-day benefit period. Payment will be made at 20% of the Medicare-approved charge.

Skilled Nursing Facility

The Fund will pay the co-insurance from the 21st day through the 100th day only.

Requires at least 3 days of prior hospitalization and entry to Skilled Nursing Facility immediately after discharge.

<table>
<thead>
<tr>
<th>Part A</th>
<th>Medicare Covers</th>
<th>Fund Covers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1-20:</td>
<td>In full</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Day 21-100:</td>
<td>All except 12.5% of the co-insurance amount.</td>
<td>12.5% of the co-insurance.</td>
</tr>
</tbody>
</table>

For detailed explanations of all of the coverages and benefits provided under the Fund’s plan as a supplement to Medicare, see the specific benefit section.
Surgical Benefits

All surgery, including organ transplants and reconstructive procedures, will be paid at 20% of the Medicare-approved charge up to $300 per 90-day benefit period.

A Medicare or other insurer’s Explanation of Benefits (EOB) must accompany claims for surgical benefits.

Vision Benefits

Vision benefits are not a covered benefit under this plan.

Veterans Benefits

Many participants neglect to take advantage of the benefits that they earned for their time spent in service. If you are a veteran who served in the active military, naval or air services including the US Army, Navy, Air Force, Marines, Coast Guard, as well as other categories of services, such as the US merchant marines, you will want to consider the benefits you are entitled to receive when considering your long term medical care benefits.

What am I entitled to receive?

Veterans are eligible to receive a wide range of medical benefits such as primary healthcare, preventive services, diagnosis and treatment, surgery, mental healthcare and substance abuse treatment, home healthcare, hospice and palliative care, nursing home care, emergency care, and pharmaceuticals, as well as financial aid for help with basic daily activities such as bathing dressing, and eating.

How do I go about enrolling for these benefits?

To enroll, you must apply at any veterans’ benefits office or VA healthcare facility. Upon enrollment, you will be placed into one of seven priority groups, based on military service and disability.

To apply for non-service related benefits, you must submit the following:

- Discharge Certificate
- Your latest available social security income letter, or if applicable the social security award letter.
- DD Form 214
- Supporting medical assessment or medical statement
- ACLF letter
- Marriage and / or birth certificates if benefits are for a spouse and / or children

The VA also has an income component and eligible veterans can receive an 80-percent reduction in co-payment rates. Generally, your assets must fall under $80,000.00 for eligibility. However, unreimbursed medical expenses may be used to reduce your income for eligibility purposes.

How do I coordinate these benefits with those that I am entitled to receive from the Welfare Fund?

If you utilize your VA benefits while you are covered under this plan, the VA will bill the Welfare Fund directly for the services they rendered. The Welfare Fund will adjudicate your VA claims according to the benefits you would be entitled to receive as a retired participant with Medicare benefits.

In order to facilitate the quick processing of your VA claims, please make sure that the VA has a copy of your most recent medical identification card on file.
Welfare Insurance Card

Retired participants utilize the exact same medical identification card as the active participants of this plan.

You have already been provided with two medical identification cards. One card is to be kept on person and the other card is to be given to the policyholder’s spouse or placed away in a safe, secure place where it can be located quickly and easily.

Eligible participants seeking a medical identification card or policyholders wishing to get additional cards or to replace a lost or stolen card may request a card by calling member services at 212-255-7657.

Participants are reminded that possession of the medical insurance identification card does not guarantee coverage. Furthermore, you are reminded that the coverage you are entitled to receive are only those that are outlined within this section of the summary plan description booklet.

Eligible participants and eligible dependents should present their card when requesting any type of covered healthcare service and request that the provider make a copy of all four sides of their medical identification card and to place it in their file.

Treat each card carefully. Carry it with you at all times or keep it in a safe place when not needed.

If you suspect unauthorized use of your card or if your card is lost or stolen, it is your responsibility to notify the Fund Office at (212) 255-7657.

Following is the information included on the identification card:

**Front Side**
- ID number.
- Group number.
- Name of the Policyholder.
- Effective date.
- Insurance Provider Name.
- Participating Provider Network.

**Inside Left**
- Medical Deductible and Co-payment Information.
- List of services that require pre-certification / prior approval.
- Prior Approval fax number.

**Inside Right**
- Disclaimer.
- Contact information for eligibility, benefits, and payment status.
- Contact information for participating provider search and provider status.
- Identification number for the electronic filing of claims.
- Address for the filing of paper claims.

**Back Side** (Benefits outlined on this side of the medical identification card are not available to participants who are eligible for Medicare Part D benefits)
- Affiliated pharmaceutical network logo.
- Pharmaceutical Plan Code.
- Insured ID number.
- Pharmaceutical phone inquiries number.
- Pharmaceutical Provider.
- Pharmaceutical Group Code.
- Pharmaceutical Deductible information.
Participants are reminded that after any medical service or completed medical procedure, they should request a copy of the claim to review that the procedures being charged were indeed performed, and to make sure that the medical provider recorded your insurance information correctly.

**Work & Family Benefits Referral Program**

The Trustees are very pleased to provide this free, unique and useful benefit to its eligible retired participants.

Unlike most of the other benefits offered through the Welfare Fund, you do not have to become ill or disabled to access this distinctive benefit.

The Work & Family Benefits program is an exclusive referral program designed to assist you whenever “work-life” concerns or experiences happen in your life or your family’s life.

**What are “work-life” concerns or experiences?** “Work-life” concerns are recognized as situations that occur in each of our lives that need immediate attention, and require a solution or information that cannot be provided by or through the other benefits outlined within this book.

**How does this referral program work?** The Work & Family Benefits, Inc. provides you and your family with personalized consultation and referral services whenever “life happens.” Simply call 800-328-4071, send an e-mail to info@wfbenefits.com or visit the Web site at www.wfbenefits.com. The WFB will try to help you find real solutions for those areas in your life that you are not an expert on, or the areas or situations where you just need assistance.

**What are some examples of “work-life” scenarios?** Some “work-life” scenarios in which the Work & Family Benefit referral program can assist you are:

- Adoption
- Back-up child care
- Caregiver support groups
- Debt management
- Emergency response
- Free simple wills
- Help for disabled relatives
- Meals on Wheels
- Nannies
- School and college planning
- Transportation
- Assisted devices for daily living
- Before and after-school child care
- Child care
- Discount legal help
- Estate Planning
- Geriatric care management
- Home health care
- Medicare and Medicaid
- Online pet care locator
- Senior centers
- Assisted living
- Camps
- Chore services
- Elder care
- Financial counseling
- Health and wellness resources
- Hospice
- Nursing homes
- Respite care
- Special needs child care

Whether you are experiencing any of the aforementioned situations or if you are experiencing some other “work-life” situation, the knowledgeable counselors at Work & Family Benefits are available for consultation, information and referrals. Do not hesitate to call 800-328-4071 or visit online at benefitfunds.iuoe15.org or www.wfbenefits.com if you should require assistance with a “work-life” scenario.

This referral program is provided to you free. The referral service is confidential and personalized to your needs.

Because of the confidentiality of this program, unless you specifically give the Work & Family counselors permission to speak to the Fund about your specific case, and vice versa, the Fund will be unable to attempt to reduce, limit or even in some cases eliminate any out-of-pocket costs that you may incur.

Accordingly, the responsibility to coordinate the Work & Family Benefit service along with any covered health and welfare benefit will remain the responsibility of the participant.
How Benefits May Be Reduced, Delayed or Lost

There are certain situations under which benefits may be reduced, delayed or lost. Most of these circumstances are spelled out in the previous sections, but your benefits will also be affected in the following situations.

- You or your beneficiary do not file a claim for benefits properly or on time.
- You or your beneficiary do not furnish the information required to complete or verify a claim.
- You or your beneficiary do not have your current address on file with the Fund Office.
- You, your dependents or your physician fraudulently submit information or claims.
- You or your dependents fail to notify the Fund Office of fraudulent charges.

You should also be aware that Fund benefits are not payable for enrolled dependents who become ineligible due to age, marriage or divorce (unless they elect and pay for COBRA benefits, described in the COBRA section of this handbook).

If any Plan mistakenly pays a bigger benefit than you’re eligible for, or pays benefits that were not authorized by the Plan, the Plan may seek any permissible remedy allowed by law to recover benefits paid in error.

Compliance with Federal Law

The Plan is governed by regulations and rulings of the Internal Revenue Service and the Department of Labor, and current Federal tax law. The Plan will always be construed to comply with these regulations, rulings and laws. Generally, Federal law takes precedence over state law.

Amendment and Termination of the Plan

The Trustees of the Fund have the authority to amend or terminate the Plan at any time and for any reason. You will be notified if the Plan is amended or terminated; however, the change may be effective before a notice is delivered to you.

If the Plan is ended, Plan assets will be applied to provide benefits in accordance with the applicable provisions of Federal law.

Your Disclosures to the Plan

If you provide false information to the Plan or commit fraud, you may be required to indemnify and repay the Plan for any losses or damages caused by your false statements or fraudulent actions. (Some examples of fraud include altering a check and knowingly cashing a voided check.) What’s more, if the Plan makes payments as a result of false statements or fraudulent actions, the Board of Trustees may elect to pursue the matter by pressing criminal charges.

Plan Administration

The Fund is a welfare benefit plan. Fund assets are accumulated under the provisions of the Trust Agreement and are held in a Trust Fund for the purpose of providing benefits to participants and defraying reasonable administrative expenses. The Fund is administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees with equal voting power.

Discretionary Authority of the Board of Trustees

The Board of Trustees governs the Fund in accordance with an Agreement and Declaration of Trust. The Trustees have the sole and absolute discretionary authority to interpret the terms of the Plan,
determine benefit eligibility, and resolve ambiguities or inconsistencies in the Plan. 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 has delegated certain administrative and operational functions to the Fund Manager and his/her staff. Most of your day-to-day questions can be answered by the Fund Office staff.

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

Use and Disclosure of Health Information

The IUOE Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund has established a policy to guard against unnecessary disclosure of your health information.

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

To make or obtain payment. The Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund may use or disclose health information for its own operations to facilitate the administration of the Local 15, 15A, 15C & 15D Welfare Fund and as necessary to provide coverage and services to all of the Fund’s participants. Health care operations include the following:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- 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, 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 Local 15, 15A, 15C & 15D Welfare Fund, including customer service and resolution of internal grievances.

- Certain marketing activities. For example, the Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund may disclose your health information to the Plan sponsor, more commonly known as the Board of Trustees, for Plan administration functions performed by the Plan sponsor on behalf of the Local 15, 15A, 15C & 15D Welfare Fund. The Local 15, 15A, 15C & 15D Welfare Fund also may provide summary health information to the Plan sponsor so that the Plan sponsor may solicit premium bids from other health plans or modify, amend or terminate the Plan.

When legally required. The Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund, 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 Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Local 15, 15A, 15C & 15D Welfare Fund has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the event of a serious threat to health or safety. The Local 15, 15A, 15C & 15D Welfare Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Local 15, 15A, 15C & 15D Welfare Fund, 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 Local 15, 15A, 15C & 15D Welfare Fund to use or disclose your health information to facilitate specified government functions.
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 Workers’ Compensation. The Local 15, 15A, 15C & 15D Welfare Fund may release your health information to the extent necessary to comply with laws relating to workers’ compensation or similar programs.

Authorization to Use or Disclose Health Information

Other than as stated above, the Local 15, 15A, 15C & 15D Welfare Fund will not disclose your health information other than with your written authorization. If you authorize the Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund 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 Fund’s disclosure of your health information to someone involved in the payment of your care. However, the Local 15, 15A, 15C & 15D Welfare Fund is not required to agree to your request. If you wish to make a request for restrictions, please contact the Fund Administrator at (212) 255-7657.

Right to receive confidential communications. You have the right to request that the Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Fund Administrator at IUOE Local 15, 15A, 15C & 15D Welfare Fund, 265 West 14th Street, 5th Floor, New York, NY 10011. The Local 15, 15A, 15C & 15D Welfare Fund 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 the Fund Administrator at IUOE Local 15, 15A, 15C & 15D Welfare Fund, 265 West 14th Street, 5th Floor, New York, NY 10011. If you request a copy of your health information, the Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund amend the records. That request may be made as long as the information is maintained by the Local 15, 15A, 15C & 15D Welfare Fund. A request for an amendment of records must be made in writing to the Fund Administrator at IUOE Local 15, 15A, 15C & 15D Welfare Fund, 265 West 14th Street, 5th Floor, New York, NY 10011. The Local 15, 15A, 15C & 15D Welfare Fund may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Local 15, 15A, 15C & 15D Welfare Fund, 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 Local 15, 15A, 15C & 15D Welfare Fund determines that the records containing your health information are accurate and complete.

Right to an accounting. You have the right to request a list of disclosures of your health information made by the Local 15, 15A, 15C & 15D Welfare Fund for any reason other than for treatment,
payment or health operations. The request must be made in writing to the Fund Administrator at IUOE Local 15, 15A, 15C & 15D Welfare Fund, 265 West 14th Street, 5th Floor, New York, NY 10011. 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 Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund will inform you in advance of the fee, if applicable.

Right to a paper copy of this Notice. You have the 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 the Fund Administrator at IUOE Local 15, 15A, 15C & 15D Welfare Fund, 265 West 14th Street, 5th Floor, New York, NY 10011 or by telephone at (212) 255-7657.

Medical Identity Theft: Medical Fraud is real. When it pertains to your personal information, members and participants alike should take the same precautions with their health care providers that they do with any other company.

Be vigilant in maintaining your records and reviewing your explanation of benefits! Medical identity theft can accelerate health care costs very quickly particularly where hospital stays or emergency room treatments are involved.

Keep in mind that these financial issues can quickly become quality of care issues, as access to required services and medications are withheld due to the perception that an individual’s insurance coverage has been exhausted.

Finally, it can take extraordinary measures and an exorbitant amount of time for a victim of medical identity theft to completely clear his or her credit rating and name.

Duties of the Local 15, 15A, 15C & 15D Welfare Fund

The Local 15, 15A, 15C & 15D Welfare Fund (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 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 the Fund Administrator at IUOE Local 15, 15A, 15C & 15D Welfare Fund, 265 West 14th Street, 5th Floor, New York, NY 10011. The Local 15, 15A, 15C & 15D Welfare Fund 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 Local 15, 15A, 15C & 15D Welfare Fund has designated Patrick J. Keenan, the Fund Administrator, as its contact person for all issues regarding patient privacy and your privacy rights. You may contact him at the IUOE Local 15, 15A, 15C & 15D Welfare Fund, 265 West 14th Street, 5th Floor, New York, NY 10011 or by telephone at (212) 255-7657.

Effective Date

This Notice is effective April 14, 2003.
If you have any questions regarding this notice, please contact the Fund Administrator.

Your rights under the Employee Retirement Income Security Act (ERISA)

As a participant in the Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C & 15D, you are entitled to certain rights and protections under the Employee Retirement Income Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to the following:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office all documents governing the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 series) and an updated Summary Plan Description (SPD). The Plan Administrator’s office may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependent children if there is 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 of Coverage Rights.

- Receive a certificate of creditable coverage, free of charge, from the health plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, and when your COBRA continuation 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 preexisting conditions and exclusions for 12 months (18 months for late enrollees) after your enrollment date in your new 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, the Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining Welfare Fund benefits or from exercising your rights under ERISA.

Enforce your rights. If your claim for a Welfare Fund 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 Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a 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 a 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 frivolous.

Assistance with your questions. If you have questions about the Plan, you should contact your 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 area office of the Pension and Welfare Benefits Administration, US Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, US Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Administration Information

1. **Plan Name:** Welfare Fund of the International Union of Operating Engineers Local 15, 15A, 15C & 15D.

2. **Edition Date:** This Summary Plan Description is produced as of September 1st, 2007.

3. **Plan Sponsor:** Board of Trustees of the Welfare Fund of the International Union of Operating Engineers Local 15, 15A, 15C & 15D.

4. **Plan Sponsor’s Employer Identification Number:** 13-6694320

5. **Plan Number:** 001

6. **Type of Plan:** Group Plan, governed by the Employee Retirement Income Security Act of 1974 (ERISA), providing Self-Funded Death Benefits, Accidental Death Benefits, Medical Benefits, Dental Benefits and Vision Care Benefits.

7. **Plan Year:** Calendar

8. **Plan Administrator:** Board of Trustees of the Welfare Fund of the International Union of Operating Engineers Local 15, 15A, 15C & 15D located at 265 West 14th Street, Room 500, New York, NY 10011, (212) 255-7657.

9. **Agent for the Service of Legal Process:** Board of Trustees of the Welfare Fund of the International Union of Operating Engineers Local 15, 15A, 15C & 15D located at 265 West 14th Street, Room 500, New York, NY 10011, (212) 255-7657. Service of process may also be made on any of the Trustees listed in section thirteen.

10. **Type of Plan Administration:** The Plan is administered by the Board of Trustees of the Welfare Fund of the International Union of Operating Engineers Local 15, 15A, 15C & 15D. All benefits are self-insured, paid out of the general assets of the Fund.

11. **Plan Funding:** Employers are required to contribute to the Welfare Fund of the International Union of Operating Engineers Local 15, 15A, 15C & 15D pursuant to a Collective Bargaining Agreement between the Employers and the Welfare Fund of the International Union of Operating Engineers Local 15, 15A, 15C & 15D. Participants and beneficiaries may receive
from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the Fund and, if so, the sponsor’s address. In addition, Participants and beneficiaries may receive from the Plan Administrator, upon written request, a copy of any such Collective Bargaining Agreement or may examine any such agreement at the Fund Office during normal business hours.

12. Participating Employers and Employee Organizations: A complete list of employers and employee organizations sponsoring the Plan may be obtained upon written request to the Fund Office and information as to whether a particular employer, or employee organization is a contributing employer, or sponsor is also available for examination at the Fund Office.

13. Trustees: The Welfare Fund’s Board of Trustees is comprised of the following:

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<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
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<tbody>
<tr>
<td>James T. Callahan</td>
<td>Union Trustee</td>
</tr>
<tr>
<td>Robert Shaw</td>
<td>Union Trustee</td>
</tr>
<tr>
<td>Lynn Mourey</td>
<td>Employer Trustee</td>
</tr>
<tr>
<td>William H. Harding</td>
<td>Employer Trustee</td>
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Other Plan Information
Items, Provisions and Thoughts Worth Repeating...

1. **Read this book in its entirety**, mark as necessary, and identify those sections most relevant to you and your family.

2. The strength of the current and future benefits of the I.U.O.E., Local 15, 15A, 15B, 15C and 15D, lay in the individual actions, or lack thereof of each of us. Therefore it is imperative that we all strive to increase and maintain our current skill set, protect our jurisdiction, collect each benefit stamp owed, submit them in a timely fashion, get an annual physical, maintain healthy habits and appropriate weight and review the explanation of benefits, letters notices and statements at the time they are issued.

3. **Medical Fraud and personal identify theft is real.** When it pertains to your personal information, members and participants alike should take the same precautions with their health care providers that they do with any other company.

   - Be vigilant in maintaining your records and reviewing your explanation of benefits! Medical identity theft can accelerate health care costs very quickly particularly where hospital stays or emergency room treatments are involved.
   - Keep in mind that these financial issues can quickly become quality of care issues, as access to required services and medications are withheld due to the perception that an individual’s insurance coverage has been exhausted.
   - Finally, it can take extraordinary measures and an exorbitant amount of time for a victim of medical identity theft to completely clear his or her credit rating and name.

4. **Annuity Loan Repayments:** In order to keep your outstanding loan current and to avoid default, participants must submit three monthly payments every quarter. The principle and interest of your loan re-payment are returned to your account in their entirety.

5. **Certain Welfare Fund benefits require prior approval.** These items are listed on your medical identification card, stressed within the description of the specific benefit, and outlined under the section titled “Prior Approval”.

6. **Redemption Periods are as follows:** Any business day during March and April, July through August, and November through December. The Fund Office will not be responsible for lost or misdirected books or for books that arrive after the closing date of the redemption period.

7. **Payment for your medical, dental and vision bills are based upon the diagnostic, CPT or ADA codes placed on your claim by your provider.** They are then adjudicated in accordance to the provisions, policies, and fee schedules, set forth within the Welfare section of this book.

   - For example, if the hospital codes your emergency room bill as a non-emergency, then the Welfare Fund will adjudicate the claim in accordance to the emergency room provision for non-emergencies. Proof as to whether the claim was deemed a true emergency lays in the emergency room notes taken by the medical practitioners at the time treatment was rendered. If or when you are contesting a claim reputed to be an emergency, you must provide the Fund Office with a set of the emergency room notes for that date of service.

8. **Outpatient mental health and substance abuse treatments must be approved annually.** For more information and for eligibility requirements, please refer to the section titled “Mental Health” & “Substance Abuse”
9. **Bi-annual verification of Student Status for the Fall Semester** must arrive at the Welfare Fund’s New York business office, no later than the last business day of the month of September.

10. **Bi-annual verification of Student Status for the Spring Semester** must arrive at the Welfare Fund’s New York business office, no later than the last business day of the month of January.

11. **Annual verification of Step Child, and/or Parental dependent status** must arrive at the Welfare Fund’s New York business office, no later than May 1.

12. **Keeping the Funds appraised of changes** of addresses, phone numbers, and family status at the time that they occur, not only facilitates better communication between the Fund Offices and you, but also avoids lapses of eligibility or worse, fraud and potential litigation.

13. **When in doubt ...... ASK!** Don’t wait for the situation to escalate or exacerbate! The Fund’s phone numbers are as follows: The Annuity Fund is 212-924-6740. The Welfare Fund is 212-255-7657.