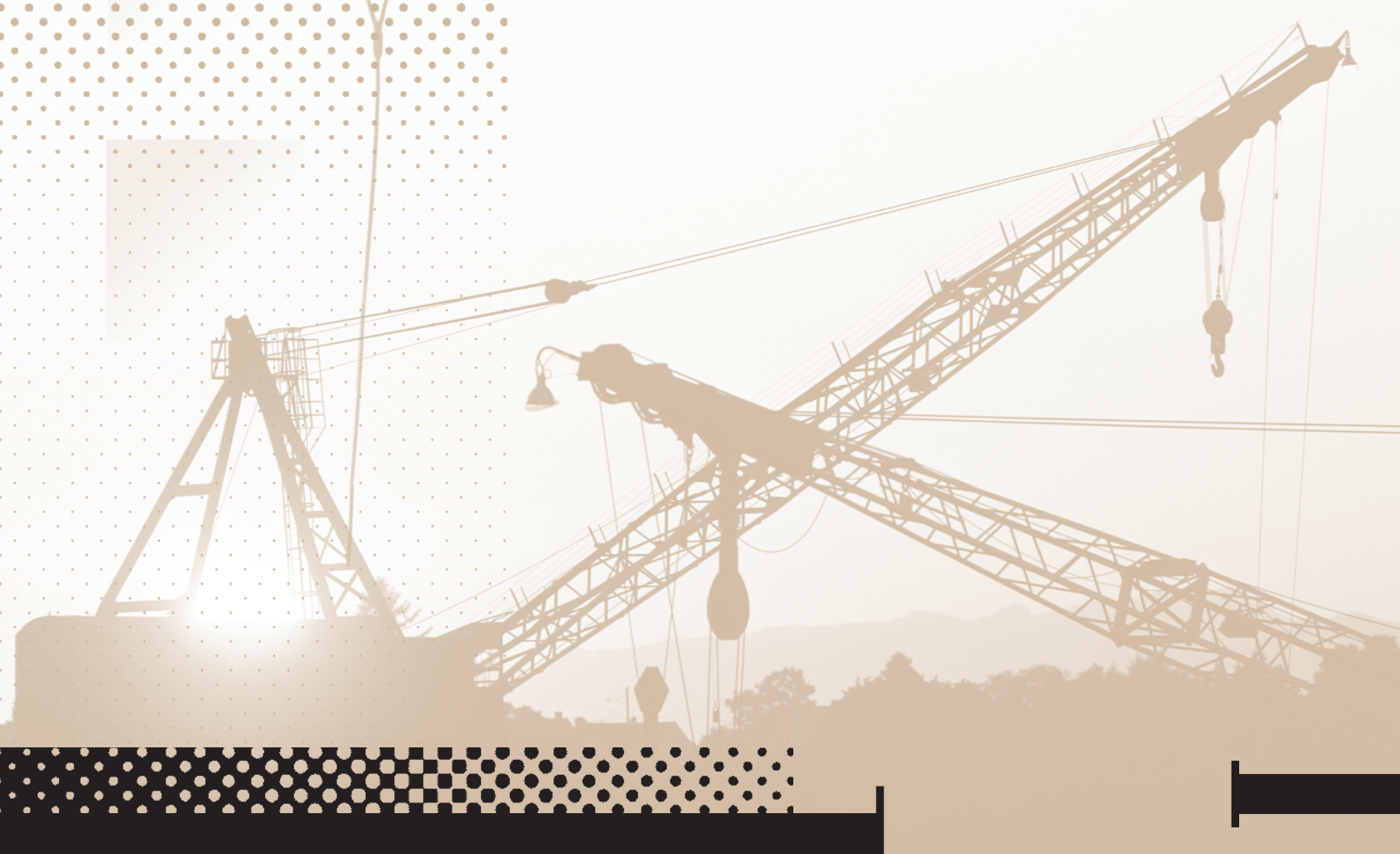
2003 >>

LOCAL 139

# OPERATING ENGINEERS

# HEALTH BENEFIT FUND

## SUMMARY PLAN DESCRIPTION



## OPERATING ENGINEERS LOCAL 139
### HEALTH BENEFIT FUND

N27 W23233 Roundy Drive
P.O. Box 160
Pewaukee, Wisconsin 53072-0160
(262) 549-9190
(800) 242-7018
www.iuoe139.org

## BOARD OF TRUSTEES

| UNION TRUSTEES | EMPLOYER TRUSTEES |
|---|---|
| Darrel J. Kane | Jack Arseneau |
| Terrance E. McGowan | Darren Lett |
| Dale A. Miller | Edward J. Hayden |
| Terry Pare | Richard W. Wanta |

## ADMINISTRATIVE MANAGER

Mary Jane DeBattista
Carday Associates, Inc.

## FUND CO-COUNSEL

Baum, Sigman, Auerbach, Neuman & Katsaros, Ltd.
200 West Adams Street, #2200
Chicago, Illinois 60606

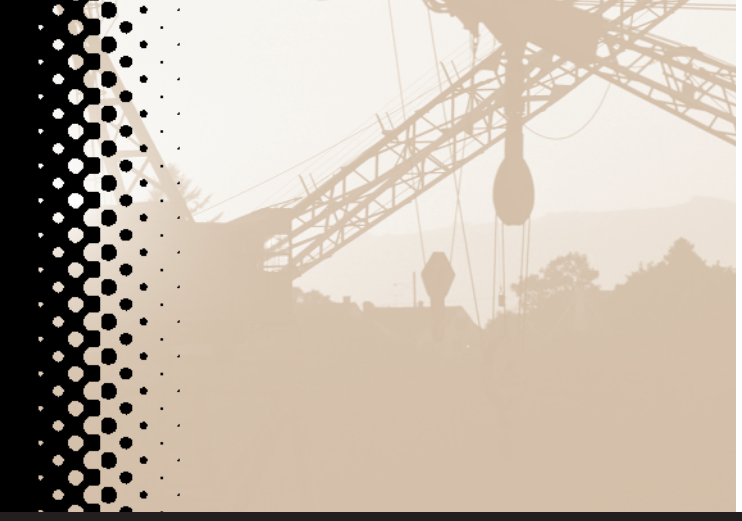
Michael, Best and Friedrich
100 East Wisconsin Avenue, Suite 3300
Milwaukee, Wisconsin 53202

## FUND ACCOUNTANT

Freyberg Hinkle Ashland Powers & Stowell s.c.
200 Bishops Way, Suite 200
Brookfield, Wisconsin 53005

## CONSULTANT AND ACTUARY

The Segal Company
101 North Wacker, Suite 500
Chicago, Illinois 60606



# TABLE OF CONTENTS


Introduction ..... 2

Eligibility And Participation ..... 4

Retiree Eligibility And Coverage ..... 12

Life Events ..... 18

Continuing Coverage ..... 24

Comprehensive Medical Benefits ..... 30

Employee Assistance Program (EAP) ..... 46

Transplant Benefits ..... 48

Dental Benefits ..... 56

Vision Benefits ..... 60

Loss Of Time (Short-Term Disability) Benefits ..... 62

Death And Dismemberment Benefits ..... 64

General Plan Exclusions And Limitations ..... 66

Claims Information ..... 70

Administrative Information ..... 88

Glossary ..... 94


**BACK POCKET**

**IN THE BACK POCKET OF THIS BOOKLET YOU WILL FIND** *SUMMARY OF BENEFITS* **AND I***MPORTANT CONTACT INFORMATION* **INSERTS.**

# INTRODUCTION

IN THIS SECTION >>


INTRODUCTION

Advantages Of Providing Benefits Through The Fund 3

About This Booklet 3


The Operating Engineers Local 139 Health Benefit Fund is a welfare benefit plan providing a comprehensive health benefit program. The Health Benefit Fund offers you and your family protection when you need:

Medical care, including Prescription drugs;

- Transplant Benefits;
- Dental care; and
- Vision care.

The Fund also provides benefits to you or your beneficiaries in the event of your:

- Loss of time at work due to a non-work related short-term Disability;
- Accidental dismemberment; or
- Death.

All benefits are provided by the Health Benefit Program and paid from the Operating Engineers Local 139 Health Benefit Fund.

The Board of Trustees determines the benefits provided in accordance with all Plan provisions. Benefits provided to different Classes of Participants may vary. In addition, any required self-payment contributions may vary depending on the benefits provided and other factors.

The Trustees retain the right, by written amendment to this Summary Plan Description (SPD), to change, add, or delete benefits, self-payment contribution rates, 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.

**GLOSSARY**

**IF YOU ARE NOT FAMILIAR WITH THE TERMS USED IN THIS BOOKLET, PLEASE CHECK THE GLOSSARY AT THE BACK. TERMS DEFINED IN THE GLOSSARY ARE CAPITALIZED THROUGHOUT THIS BOOKLET.**

## ADVANTAGES OF PROVIDING BENEFITS THROUGH THE FUND

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

- 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.
- Because the Fund provides coverage for thousands of people, it can obtain better benefits at lower costs than you could purchase individually.
- A Fund-sponsored plan generally can offer protection to everyone. This means even those people who might be considered uninsurable can get coverage.

## ABOUT THIS BOOKLET

This booklet is intended to give you an understanding of the benefits provided by the Operating Engineers Local 139 Health Benefit Fund, effective as of January 1, 2003.

This booklet is also intended to give you an understanding of how the Fund operates. We've tried to organize the information in a way that will be useful to you. The booklet includes several sections including:

- An **eligibility** section that tells you how you become a member of the Plan, who in your family is eligible for coverage, what you need to do to continue to be eligible, when coverage under the Plan ends, and what you need to do to reinstate your eligibility.
- A **life events** section designed to show you how your benefits are affected by the different events that can occur in your life and how your benefits work, including information about what you need to do when those events occur.
- Several sections that provide **detailed information** about each of the different types of coverage provided through the Plan, including medical, Prescription drug, transplant, dental, vision, loss of time (short-term Disability), and death and dismemberment benefits as well as what is not covered under the Plan.
- A **how-to** section on filing claims, including what you need to do if a claim is denied.
- An **administrative information** section, that includes general Plan information and your rights as a Participant in the Plan.
- A **glossary** that defines important words that are used throughout this booklet.
- A back pocket that includes:
  - > A listing of **important contact information** – so when you need to call someone, you'll know where to look for the phone number; and
  - > A ***Summary Of Benefits*** that gives you a brief overview of all the benefits available to you through the Fund.

In the future, as your benefits change, we'll send you information that you can store in the back pocket. This will allow you to have the most up-to-date information on all your health and welfare benefits in the same place.

We urge you to read this information and, if you're married, share it with your spouse. Also, we recommend that you keep this booklet with your important papers so you can refer to it and update it when needed.

Sincerely,
Board of Trustees

# ELIGIBILITY & PARTICIPATION

IN THIS SECTION >>


BECOMING ELIGIBLE 4
- You 4
- Your Dependents 4
  - When Your Spouse Is Eligible For Other Coverage 5

PREEXISTING CONDITION PROVISION 6

THE QUARTERS SYSTEM 6
- How Eligibility Quarters Are Earned 7

INITIAL ELIGIBILITY 7
- If You Are A Bargaining Unit Or Alumni Participant 7
  - If You Are A Bargaining Unit Employee Receiving Workers' Compensation Benefits 8
- If You Are A Non-Bargaining Unit Participant 8
  - If You Are A Fund-Related Non-Bargaining Unit Participant 8
  - If You Are A Regular Non-Bargaining Unit Participant 8
  - If You Are A Newly Organized Employer Participant 8

CONTINUING ELIGIBILITY 9
- Bank Of Hours 9
- Quarterly Status Report 10

LOSING ELIGIBILITY 10
- You 10
- Your Dependents 10

REINSTATING ELIGIBILITY 11

CHANGE OF ELIGIBILITY RULES AND BENEFITS 11


## BECOMING ELIGIBLE

This section describes the eligibility rules for Active employees. For eligibility information for Retired and Disabled employees and surviving Dependents, see pages 12-17.

### YOU

You may become eligible for benefits if the Fund receives (or received) Employer contributions made on your behalf for your hours worked. You must satisfy certain eligibility requirements relating to contributions for hours of work. In addition, you must work (or have worked) for an Employer that has entered into a collective bargaining agreement or a participation agreement with the Trustees.

### YOUR DEPENDENTS

Your Dependents become eligible for coverage on the same date you become eligible, or if later, on the date you acquire an eligible Dependent. However, if you do not notify the Fund Office within 30 days of when your new Dependent becomes eligible, your Dependent's coverage will not begin until the first day of the month ***after*** you complete and return an Enrollment Card to the Fund Office adding the Dependent.

In general, your Dependents are your:

- Spouse; and
- Unmarried children who:
  - > Depend on you for support and maintenance;
  - > Are living with you in a regular parent-child relationship; and
  - > You are entitled to claim as an exemption for income tax purposes.

**THE INFORMATION CONTAINED IN THIS SECTION RELATES TO ELIGIBILITY FOR ACTIVE EMPLOYEES. FOR ELIGIBILITY INFORMATION FOR RETIRED AND DISABLED EMPLOYEES AND SURVIVING DEPENDENTS, SEE PAGES 12-17.**

**THE MONTHLY AMOUNT PER STUDENT TO CONTINUE COVERAGE FROM AGE 19 THROUGH ATTAINMENT OF AGE 25 IS $100. HOWEVER, THIS AMOUNT IS SUBJECT TO CHANGE, CONTACT THE FUND OFFICE FOR THE MOST CURRENT AMOUNT.**

Your Dependent child is covered up to his/her 19th birthday. Coverage for your child may be continued beyond the attainment of age 19 if your child meets the previous conditions and:

- His/her primary occupation and activity is that of a full-time student in an accredited school, in which case eligibility for coverage may continue to the attainment of age 25.

  If your child is a full-time student and you want to continue his/her coverage beyond the attainment of age 19 (through attainment of age 25), you may elect to make a monthly contribution per student to continue coverage. You will be required to submit documentation verifying his/her status as a full-time student at an accredited school; or

- He/she is incapable of self-sustaining employment due to a mental or physical handicap. Coverage for a child who is mentally or physically handicapped will continue with no monthly contribution.

The Plan also covers children as required by a valid Qualified Medical Child Support Order (QMCSO) issued by a court. The Fund Office will review the order to see if it meets legal requirements.

For a more complete definition of eligible Dependent, see page 96.

### When Your Spouse Is Eligible For Other Coverage

If your spouse is employed and is eligible for medical and/or Prescription drug coverage through his or her employer, your spouse must enroll for that coverage. If your spouse is eligible for other coverage and does not enroll for that coverage, he or she will not be covered under this Plan.

Therefore, it is essential that your spouse enroll for such other coverage as soon as possible. Once your spouse is covered under the other plan, your spouse will be covered under this Plan. Your spouse's other Plan will be his or her primary plan, which means that Plan will pay benefits first. Costs not covered under the other plan may then be submitted to this Plan. That means your spouse may receive more benefits than if he or she were covered under only one plan.

When you are first eligible, you must:

- Complete a Family Information Sheet and return it to the Fund Office, regardless of whether or not your spouse has coverage through his/her employer.
- If your spouse is employed but is not eligible for other coverage, provide a letter to the Fund Office from your spouse's employer, stating that no other coverage is available.
- If your spouse is not employed, complete and return a notarized Family Information Sheet, signed by you, stating that your spouse is not employed.

If the Fund Office learns that your spouse is eligible for other coverage but has refused it, your spouse's coverage under the Fund will be terminated immediately. Written notice will be sent to you when the coverage ends.

Your coverage and your other Dependents' coverage is not affected by your spouse's other coverage, regardless of whether or not you are covered under your spouse's plan. However, if you or your other Dependents are also covered under your spouse's plan, benefits will be coordinated in accordance with the Plan's Coordination of Benefits provisions (see page 78).

**IF A CHILD, WHILE UNDER AGE 25, RETURNS TO SCHOOL AS A FULL-TIME STUDENT, HE OR SHE WILL BE ELIGIBLE FOR COVERAGE AGAIN UNDER THE PLAN. HOWEVER, HE OR SHE MAY BE SUBJECT TO THE PLAN'S PREEXISTING CONDITION PROVISIONS.**

## PREEXISTING CONDITION PROVISION

If you or one of your eligible Dependents receive medical care, treatment, service, or consultation for an Illness or Injury within the six-month period immediately preceding your eligibility for coverage under the Plan, you are considered to have a Preexisting Condition under this Plan. Care means the diagnosis, treatment, or the presence of symptoms that would cause a prudent person to seek care, whether or not care was sought.

The Preexisting Condition provision does not apply to pregnancy or to children who have been adopted or placed in your home for adoption.

No benefits are payable under the Plan for a Preexisting Condition for a certain period of time. If the Preexisting Condition is:

- Yours, no benefits are payable until you have been covered under the Plan for six consecutive months; or
- Your Dependent's, no benefits are payable until your Dependent has been covered under the Plan for 12 consecutive months.

The above time periods will be reduced by the number of days you were covered under prior coverage, excluding coverage before any break in your prior health insurance coverage of 63 days or more. You will need to submit a Certificate of Creditable Coverage (HIPAA) from your prior health care carrier to the Fund Office.

## THE QUARTERS SYSTEM

The Health Benefit Fund is designed to pay benefits based on a "Quarters System," which determines your eligibility to receive benefits. The Fund has two kinds of quarters that affect your benefits. They are:

- Work Quarters; and
- Eligibility Quarters.

It is important for you to understand the difference between these two types of quarters and how they relate to each other.

During a Work Quarter, you establish your eligibility for benefits for a later time period. A Work Quarter is a calendar quarter that represents a period of three work months during which contributions are made to the Fund on your behalf by your Employer. An Eligibility Quarter is the period of time you are eligible for benefits.

In short, you earn a right to benefits during a Work Quarter. Your right to benefits is payable to you in the Eligibility Quarter that follows.

**PREEXISTING CONDITION PROVISION EXAMPLE**

LUKE WAS COVERED UNDER A FORMER EMPLOYER'S PLAN FOR FOUR MONTHS. HIS PREEXISTING CONDITION PROVISION FOR COVERAGE UNDER THIS PLAN WOULD BE REDUCED TO TWO MONTHS FOR HIMSELF AND EIGHT MONTHS FOR HIS ELIGIBLE DEPENDENTS (PROVIDED THEY WERE COVERED UNDER LUKE'S FORMER PLAN AS WELL).

IF LUKE HAD EXPERIENCED A BREAK OF 63 DAYS OR MORE DURING WHICH HE HAD NO HEALTH COVERAGE OR DID NOT START WORKING TO GAIN COVERAGE, THE PREEXISTING CONDITION PERIOD UNDER THE PLAN WOULD NOT BE REDUCED.

**WHEN YOU ARE INITIALLY ELIGIBLE, YOU MUST COMPLETE AND SIGN AN ENROLLMENT CARD, SEE PAGE 5.**

| Work Performed During This Work Quarter: | Determines Your Eligibility For This Eligibility Quarter: |
|---|---|
| January, February, March | June, July, August |
| April, May, June | September, October, November |
| July, August, September | December, January, February |
| October, November, December | March, April, May |

### HOW ELIGIBILITY QUARTERS ARE EARNED

You earn credit for an Eligibility Quarter when the Fund receives contributions from Employers on your behalf for:

- 300 or more hours in the preceding Work Quarter; or
- 1,200 or more hours in the preceding four Work Quarters.

You continue to earn credit for hours if you are receiving Loss of Time Benefits from the Fund or if you notify the Fund Office, in writing, that you are receiving Workers' Compensation benefits. You must include a letter from either your Employer or the Workers' Compensation carrier (or a copy of your Workers' Compensation check). In either case, you will receive credit for up to 25 hours of contributions each week, not to exceed 100 hours per month, for up to a maximum of:

- 24 months if you are receiving Workers' Compensation benefits; or
- 26 weeks if you are receiving Loss of Time Benefits.

## INITIAL ELIGIBILITY

### IF YOU ARE A BARGAINING UNIT OR ALUMNI PARTICIPANT

You become eligible to receive benefits on the first of the month after a Work Quarter in which the Fund receives at least 300 hours of Employer contributions made on your behalf. However, Initial Eligibility cannot be established as a result of reciprocity hours transferred from another Fund.

The initial period of eligibility is five months. Remember, however, all newly eligible Participants and their Dependents are subject to the Preexisting Condition provision described on page 6. If you were previously covered under the Plan, but you have not been eligible for benefits under the Plan for 36 months (from the last date you were eligible), you are considered a newly eligible Participant.

### INITIAL ELIGIBILITY FOR BENEFITS EXAMPLE

**MIKE STARTED WORKING AS AN OPERATING ENGINEER ON MAY 1 AND WORKED 350 HOURS IN MAY AND JUNE. THE WORK QUARTER HE STARTED WORKING IN IS APRIL, MAY, AND JUNE. THE FUND RECEIVED EMPLOYER CONTRIBUTIONS FOR THESE HOURS AND THEREFORE MIKE SATISFIED THE ELIGIBILITY REQUIREMENTS AND EARNS INITIAL ELIGIBILITY; MEANING MIKE IS COVERED FOR BENEFITS BY THE FUND EFFECTIVE JULY 1 THROUGH NOVEMBER 30. THE INITIAL PERIOD OF ELIGIBILITY FOR BENEFITS INCLUDES THE ELIGIBILITY QUARTER THAT MIKE EARNED (SEPTEMBER, OCTOBER, AND NOVEMBER). SINCE MIKE IS A NEW EMPLOYEE, HE IS COVERED BY THE FUND FOR THE MONTHS OF JULY AND AUGUST TOO.**

**THE SUBSECTION INVOLVING WORKERS' COMPENSATION BENEFITS DOES NOT APPLY TO NON-BARGAINING UNIT OR ALUMNI PARTICIPANTS.**

### If You Are A Bargaining Unit Employee Receiving Workers' Compensation Benefits

If you are a Bargaining Unit Participant and a Disability prevents you from working after you become eligible, you will be given credit for 25 hours per week up to 100 hours per month, for up to eight Work Quarters to help maintain your eligibility for benefits.

You will receive the disability hours credit if:

- You are receiving temporary total or permanent total disability weekly benefits from Workers' Compensation as a result of your Injury or Sickness;
- Your Disability was due to employment with an Employer for which employer contributions are payable to the Fund;
- You submit proof to the Fund Office that you are receiving temporary total or permanent total disability weekly benefits from Workers' Compensation; and
- You provide medical evidence satisfactory to the Trustees, upon request.

You will not receive the credit if you are receiving temporary partial disability or total partial disability benefits from Workers' Compensation.

If any Injury or Sickness for which Workers' Compensation Benefits are paid allows you to return to work but later requires additional treatment, disability hours can be credited while you are receiving additional treatment, for up to a total of eight Work Quarters.

## IF YOU ARE A NON-BARGAINING UNIT PARTICIPANT

### If You Are A Fund-Related Non-Bargaining Unit Participant

You are considered a Fund-Related Non-Bargaining Unit Participant if you are an employee of the Union, the Associations, a peripheral Fund, or the Administrative Manager. You are subject to the same eligibility rules of all Active bargaining unit Operating Engineer Participants.

However, you are not allowed to make self-payment contributions unless you are also an Operating Engineer available for work.

### If You Are A Regular Non-Bargaining Unit Participant

You are a regular Non-Bargaining Unit Participant if you do not perform work under a collective bargaining agreement, but your Employer is signatory to a Non-Bargaining Unit Agreement with the Trustees of the Fund that allows for your participation.

Your eligibility begins on the first day of the third month of employment, provided your Employer has made contributions on your behalf and has:

- Chosen this Fund's coverage for employees who are not Operating Engineers; and
- Signed a "Non-Bargaining Unit Participation Agreement" that has been accepted by the Trustees.

Your eligibility continues on a month-to-month basis during the remainder of your employment as long as your Employer:

- Makes the required contributions on your behalf; and
- Complies with the non-discrimination rule requirements of the Agreement.

As a regular Non-Bargaining Unit Participant, you are not eligible to make self-payment contributions for coverage, and can only make COBRA Continuation Coverage payments if your employment terminates.

### If You Are A Newly Organized Employer Participant

If you are employed by a newly organized Employer, your Initial Eligibility begins on the first day of the month following 160 hours worked for which contributions have been made to the Fund on your behalf. You will then remain eligible until the beginning of the next Eligibility Quarter.

However, if the hours were worked in the last month of the Work Quarter, you will be eligible the beginning of the next month and through the end of the next Eligibility Quarter.

## CONTINUING ELIGIBILITY

Once you earn your Initial Eligibility, you continue to earn **three-month** periods of eligibility called Eligibility Quarters. You stay eligible as long as you work at least 300 hours per Work Quarter and the Fund receives Employer contributions for those hours. If you do not work at least 300 hours in a Work Quarter, you can still be eligible if at least 1,200 hours of Employer contributions have been made on your behalf in the last four Work Quarters. The Fund always looks at your last four Work Quarters, which continually change (see example below).

### BANK OF HOURS

As you work, you build a "bank of hours." This bank holds all your reported hours for the **last four Work Quarters**. The hours accumulated in your bank help you keep your eligibility. If you do not have the required 300 hours in a Work Quarter, you will keep your eligibility as long as you have at least 1,200 hours in your bank. **Your bank of hours changes at the end of each Work Quarter because only hours from your last four Work Quarters are counted.**

**Continuing Your Eligibility Example**

As a new employee starting on May 1, Mike earned Initial Eligibility for July, August, September, October, and November because his Employer made 350 hours worth of contributions on his behalf for May and June.

After meeting the Initial Eligibility requirements, Mike worked over 300 hours in each of his first four Work Quarters, so his eligibility continued. In his fifth Work Quarter, Mike worked only 230 hours for which his Employer made contributions. Mike's eligibility will continue because over his last four Work Quarters, he had built a "bank of hours" sufficient to continue his coverage.

The bank holds the total of all hours for his last four Work Quarters. Mike had 1,300 hours in his bank at the end of the Work Quarter that he worked only 230 hours. This is more than the minimum of 1,200—so his eligibility continues.

| Work Quarter | Reported Hours | Bank Of Hours | Earns Eligibility For Eligibility Quarter |
|---|---|---|---|
| April, May, June | 350 | 350 | July, August, September, October, November |
| July, August, September | 350 | 350+350=700 | December, January, February |
| October, November, December | 370 | 370+700=1,070 | March, April, May |
| January, February, March | 230 | 230+1,070=1,300 | June, July, August |

However, in the next Work Quarter (April, May, June), Mike again works only 240 hours for which his Employer made contributions. His eligibility will not continue because his total hours worked over the last four Work Quarters is only 1,190 (350 + 370 + 230 + 240), which is less than the 1,200 minimum.

**IF YOU DO NOT AGREE WITH THE HOURS REPORTED ON YOUR QUARTERLY STATUS REPORT, RETURN THE REPORT TO THE FUND OFFICE, ALONG WITH ANY PAYROLL CHECK STUBS OR OTHER SUPPORTING DOCUMENTATION.**

### QUARTERLY STATUS REPORT

If you are eligible for benefits prior to the beginning of each Eligibility Quarter (March, June, September, and December), you will receive a Quarterly Status Report. This report contains the name of the contractor(s), the month(s) worked, and the number of hours reported to the Fund on your behalf during the most recent Work Quarter. It also indicates the total number of hours you had reported on your behalf for the four most recent Work Quarters.

On the lower left side of the report are two Quarterly Benefit Eligibility ID cards that can be used as identification when requesting medical, dental, or vision services. Tear the Eligibility ID card(s) out, keep one and, if you're married, give the other to your spouse. When you are initially eligible for benefits you will receive a Prescription Drug ID card. Use your Prescription Drug ID card to receive your Prescriptions at discounted prices when you go to a Preferred Provider pharmacy.

## LOSING ELIGIBILITY

The Health Benefit 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

You will lose eligibility for coverage if:

- Fewer than:
  - > 300 hours of Employer contributions are received on your behalf in a Work Quarter; or
  - > 1,200 hours of Employer contributions are received on your behalf in the preceding four Work Quarters;
- You have made the maximum of six consecutive quarterly self-payment contributions (if eligible, see page 24);
- You are a bargaining unit employee and you work for a non-participating Employer in the construction industry;
- You do not make the required self-payment contributions on time;
- You are inducted into the Armed Forces (see page 21); or
- There is a written amendment to this SPD that affects eligibility.

### YOUR DEPENDENTS

If you lose eligibility for coverage for any reason, your spouse and eligible Dependent children will also lose eligibility.

However, 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 Coverage.

**IF YOU WORK FOR A NON-PARTICIPATING EMPLOYER IN THE CONSTRUCTION INDUSTRY, THE FUND OFFICE WILL NOTIFY YOU THAT YOUR BENEFIT COVERAGE (AND YOUR DEPENDENTS' BENEFIT COVERAGE) WILL END ON THE FIRST DAY OF THE MONTH FOLLOWING THE NOTICE OR, IF LATER, 20 DAYS FOLLOWING THE NOTICE. YOU WILL NOT BE PERMITTED TO MAKE SELF-PAYMENT CONTRIBUTIONS TO CONTINUE YOUR ELIGIBILITY. HOWEVER, YOU MAY BE ELIGIBLE FOR COBRA CONTINUATION COVERAGE, SEE PAGE 27.**

In addition, your eligible Dependent child loses eligibility on his or her 19th birthday, unless your child is mentally or physically handicapped or a full-time student. If your child is a full-time student you may continue eligibility for coverage through attainment of age 25 by making monthly contributions for coverage.

## REINSTATING ELIGIBILITY

If you lose your eligibility for coverage, you can become eligible for coverage again if you have 300 hours of contributions made on your behalf within a Work Quarter. However, unlike when you are initially eligible, when coverage is reinstated, your coverage begins on the first day of the Eligibility Quarter and consists of just that three month Eligibility Quarter. When you are initially eligible, your eligibility begins on the first of the month following the end of the Work Quarter and consists of five months.

In addition, if your eligibility is reinstated, you are subject to the Fund's Preexisting Condition provision, as described on page 6.

If you lose eligibility because of induction into the Armed Forces, the Initial Eligibility and/or Reinstating Eligibility rules may be waived. See page 21 for more information regarding coverage when you are inducted into the Armed Forces.

If you lose your eligibility due to full-time employment with the International Union, you can reinstate your status in the Fund provided:

- You were eligible for benefit coverage from the Fund immediately preceding your full-time employment with the International Union; and
- Upon termination of such employment with the International Union:
  - > You immediately begin employment under a contract requiring contributions to the Fund; or
  - > You immediately apply for retiree coverage or postponement of retiree coverage under the Plan.

## 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 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 SPD.

Whenever policies (such as self-payment contribution rates, benefits provided, etc.) change, you will be 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.

**REINSTATEMENT EXAMPLE**

**MIKE EARNED INITIAL ELIGIBILITY IN JULY, BASED ON 300 HOURS IN APRIL, MAY, AND JUNE AND STAYED ELIGIBLE THROUGH NOVEMBER. MIKE DID NOT WORK IN JULY, AUGUST, AND SEPTEMBER, AND DID NOT MAKE SELF-PAYMENT CONTRIBUTIONS, SO HE WAS NO LONGER ELIGIBLE FOR DECEMBER, JANUARY, AND FEBRUARY. IF MIKE WORKS MORE THAN 300 HOURS IN OCTOBER, NOVEMBER, AND DECEMBER, HE WILL BE REINSTATED AND ELIGIBLE FOR COVERAGE IN THE FOLLOWING MARCH, APRIL, AND MAY. HE DOES NOT GET FIVE MONTHS OF ELIGIBILITY.**

# RETIREE ELIGIBILITY & COVERAGE

IN THIS SECTION >>


ELIGIBILITY 12
Service Credit 13
RETIREE IN-AND-OUT PROGRAM 14
RETIREE COVERAGE 14
SELF-PAYMENT CONTRIBUTIONS FOR RETIREE COVERAGE 14
Pre-Funded Program Self-Payment Contributions 15
Disabled Retired Participants 16
Surviving Spouses 16
Funded Program Self-Payment Contributions 17
MAKING YOUR RETIREE COVERAGE SELF-PAYMENTS 17


When you are no longer actively employed due to retirement or Disability and you are eligible for retiree coverage, you must enroll for such coverage. In addition, in the event of your death, your surviving spouse may enroll for retiree coverage.

## ELIGIBILITY

You are eligible for retiree coverage if you are Retired. For plan purposes, Retired means:

- ***Normal Retired***: You are at least age 62 with 10 or more service credits;
- ***Early Retired***: You are between the ages of 55 and 62 with 10 or more service credits;
- ***Surviving Spouses***: You are the surviving spouse of a Participant that had 10 or more service credits; and
- ***Disabled Retired***: You are entitled to a Social Security Disability award at any age with 10 or more service credits.

***If you are a Bargaining Unit, Alumni, or Fund-Related Non-Bargaining Unit Participant,*** to be eligible for retiree coverage, you must:

- Be and remain a member in good standing of or maintain continuous payment of a service fee to Local 139 (this does not apply to Fund-Related Non-Bargaining Unit Participants);
- Be eligible for coverage through the Fund at the time of your retirement (or Disability); and

**IF YOU DO NOT HAVE 10 OR MORE SERVICE CREDITS BUT OTHERWISE MEET THE ELIGIBILITY REQUIREMENTS FOR RETIREE COVERAGE, YOU ARE STILL ELIGIBLE FOR RETIREE COVERAGE BUT YOU ARE REQUIRED TO PAY THE FULL COST FOR THAT COVERAGE (AS DETERMINED BY THE BOARD OF TRUSTEES).**

**SERVICE CREDITS**

**YOU ARE AWARDED SERVICE CREDITS BASED ON YOUR EMPLOYER CONTRIBUTION HOURS EACH CALENDAR YEAR, SEE PAGE 13 FOR MORE INFORMATION.**

**THE TRUSTEES MAY CHANGE SELF-PAYMENT CONTRIBUTION RATES AND CHANGE OR DISCONTINUE BENEFITS FOR RETIREES AT ANY TIME.**

- Have been credited with Employer contributions to the Health Benefit Fund for at least:
  - > 3,000 hours in the three consecutive Calendar Years immediately preceding retirement;
  - > 4,000 hours in the four consecutive Calendar Years immediately preceding retirement; or
  - > 5,000 hours in the five consecutive Calendar Years immediately preceding retirement.

Hours for which you make self-payment contributions are not included toward meeting the previous hour requirements.

*If you are a Non-Bargaining Unit Employee,* you must:

- Be receiving Social Security retirement benefits; or
- Not be receiving wages subject to Social Security taxes from any Employer (you will be required to provide a copy of your federal and state income tax returns to the Fund Office).

For purposes of determining eligibility for retiree coverage, if you are employed full-time with the International Union, you will be credited as if you remained continuously eligible provided:

- You were eligible for benefit coverage through the Fund immediately preceding your full-time employment with the International Union; and
- Upon termination of such employment by the International Union, you immediately:
  - > Begin employment under a contract requiring contributions to the Fund; or
  - > Apply for retiree coverage by contacting the Fund Office.

### SERVICE CREDIT

Service credits are awarded for your hours of Employer contributions each Calendar Year, including hours worked under a reciprocal agreement. You can earn up to a maximum of 42 Service Credits. Service credits are used to determine your eligibility for retiree coverage as well as to determine the amount of your self-payment contributions for retiree coverage.

Service credits are awarded based on your hours of Employer contributions each Calendar Year as follows:

| Hours Of Employer Contributions In A Calendar Year* | Service Credit Earned For That Calendar Year |
|---|---|
| 2,400 hours or more | 1.40 |
| 2,100 – 2,399 hours | 1.30 |
| 1,800 – 2,099 hours | 1.20 |
| 1,500 – 1,799 hours | 1.10 |
| 1,250 – 1,499 hours | 1.00 |
| 1,000 – 1,249 hours | 0.75 |
| 750 – 999 hours | 0.50 |
| 500 – 749 hours | 0.25 |
| 0 – 499 hours | 0.00 |

* *Any hours for which you make self-payment contributions to continue coverage or are credited with during a Disability for which you are receiving Loss of Time or Workers Compensation Benefits are not counted in determining your hours of employer contributions.*

From January 1, 1971 through January 1, 1975, the Fund Office does not have Employer contribution information available. However, you will receive one full credit for each year you were a Local Union No. 139 member, as verified by Local Union No. 139 records. If you were not a Local Union No. 139 member for any year during that time, no credit will be awarded for that year.

When looking at hours of Employer contributions made on your behalf, the Fund includes reciprocal hours of Employer contributions made on your behalf. However, these hours are prorated, using the contribution rate as the base rate. Contact the Fund Office for more information about reciprocal hours.

**SELF-PAYMENT HOURS ARE NOT CONSIDERED HOURS OF EMPLOYER CONTRIBUTIONS FOR EARNING SERVICE CREDITS.**

**SINCE THE FUND COORDINATES BENEFITS WITH MEDICARE, YOU AND ANY OF YOUR ELIGIBLE DEPENDENTS MUST ENROLL IN MEDICARE PARTS A AND B AS SOON AS YOU ARE ELIGIBLE.**

## RETIREE IN-AND-OUT PROGRAM

When you retire, if you are eligible, you may continue coverage for yourself and your Dependents under the retiree plan. However, you may delay participation in the retiree plan if you have medical coverage available through another Group Plan, such as through your spouse's employer. Under the provisions of the Retiree In-and-Out Program, you and your spouse may postpone coverage and maintain your eligibility to participate in the retiree program at a later date.

You must file a written notice of your decision to delay retiree coverage with the Fund Office. You may request a Retiree In-and-Out Program Participation Form from the Fund Office. Notice must be provided within 60 days immediately following the date you first become eligible for retiree coverage. If you choose retiree coverage when you first retire, you may be eligible to opt out of this coverage and resume coverage at a later time.

Once your other coverage ends, you will need to:

- File a written application with the Fund Office within 60 days following the date your other coverage ends;
- Provide proof that you were continuously covered by another plan since the date you elected to delay your coverage under this Plan; and
- Make the required self-payment contribution for coverage.

Once you retire and begin making retiree self-payment contributions, the full monthly self-payment contribution is required unless you reestablish eligibility as an Active Participant, as described on page 11.

## RETIREE COVERAGE

When you are eligible for retiree coverage, Dependent coverage is available for those Dependents that were eligible for coverage at the time of your retirement. If you are married when retiree coverage begins, your spouse is eligible for coverage. If your spouse dies and you subsequently remarry, your new spouse is also eligible for coverage under the Plan. However, if you are eligible for retiree coverage as a surviving spouse and you remarry, your new spouse is not eligible for coverage under the Plan. In addition, if you are under age 65 at the time of your remarriage, you will no longer be eligible for coverage under the Plan.

Once you are no longer considered "Active," you and any of your Dependents who are Eligible for Medicare or who may become Eligible for Medicare **must** enroll in Medicare Parts A and B. The Fund coordinates benefits with Medicare when you are eligible.

## SELF-PAYMENT CONTRIBUTIONS FOR RETIREE COVERAGE

Self-payment contributions are required for retiree coverage under the Plan. Health care costs continue to increase each year. In addition, retiree usage of health care services generally increases each year. To ensure that the Fund can provide retiree benefits now and in the future and that your self-payment contributions are kept as low as possible, the Trustees of the Plan continually evaluate how to fund retiree benefits.

**THE AMOUNT OF THE RETIREE SELF-PAYMENT CONTRIBUTION IS SET BY THE TRUSTEES. IN ADDITION, THE TRUSTEES DETERMINE THE BENEFITS PROVIDED TO RETIREES, WHICH WILL NOT BE THE SAME AS THOSE PROVIDED TO ACTIVE PARTICIPANTS.**

**SERVICE CREDIT**

**YOU ARE AWARDED SERVICE CREDITS BASED ON YOUR EMPLOYER CONTRIBUTION HOURS EACH CALENDAR YEAR, UP TO A MAXIMUM OF 42 SERVICE CREDITS (SEE PAGE 13).**

The Plan uses two methods to fund retiree benefits – the pre-funded method and the funded method. The amount of the self-payment contribution and how it is determined is different under each method.

The Fund adopted the pre-funded method as of January 1, 2003. In general, this method will apply to Participants retiring on or after January 1, 2003. However, individual Employers must elect to participate in the pre-funded program. If you do not have the necessary credits under the pre-funded program, your self-payment contributions will be determined under the funded program method, as described beginning on page 17.

*If you were receiving retiree coverage as of January 1, 2003,* your retiree benefits are provided under the funded program method, see page 17. You will not be covered under the pre-funded program, even if you subsequently return to work.

### PRE-FUNDED PROGRAM SELF-PAYMENT CONTRIBUTIONS

The amount of your self-payment contribution will depend on:

- The cost of providing coverage;
- The number of service credits you have earned; and
- Your age at retirement.

Your self-payment contribution amount will be the cost of retiree coverage reduced by your service credit amount. The Fund Office will calculate your self-payment contribution amount when you apply for retiree coverage and as costs or rates change. If the cost of retiree coverage increases due to inflation and/or utilization, your self-payment contribution will also increase.

The cost of retiree coverage will be determined by the Board of Trustees based on the cost of providing such coverage. The cost will be reviewed annually and adjusted to reflect the actual cost of providing retiree coverage. Contact the Fund Office for the most-up-to date cost information.

The longer you work under the Plan, the less you will have to pay for retiree coverage. This program is effective for retirements on or after January 1, 2003. However, you may receive service credits for all of your covered employment under the Plan, including your covered employment before January 1, 2003.

To receive service credit before June 1, 2002, prefunding contributions must have been made on your behalf beginning:

- With the work month of June 2002; or
- Immediately following the date a wage allocation took affect if the allocation took place after June 2003.

No past service credits are provided if prefunding contributions are not made on your behalf immediately following June 2002, or, if later, the date of your employer's contract reallocation. In addition, no past service credits are provided for Non-Bargaining Unit Participants if their Employer did not choose to participate in the program as of June 2002.

**GENERALLY, YOUR SERVICE CREDIT RATE IS DETERMINED AS OF YOUR AGE WHEN YOU INITIALLY RETIRE. HOWEVER, IF YOU SUBSEQUENTLY RETURN TO WORK AND HAVE 1,000 OR MORE HOURS OF EMPLOYER CONTRIBUTIONS WITHIN ONE CALENDAR YEAR, YOUR SERVICE CREDIT RATE MAY BE ADJUSTED BY AGE WHEN YOU SUBSEQUENTLY RETIRE. YOU MAY ONLY HAVE YOUR SERVICE CREDIT RATE ADJUSTED ONCE.**

**IF YOU WORK FOR A NON-PARTICIPATING EMPLOYER IN THE CONSTRUCTION INDUSTRY OR ARE EXPELLED FROM THE UNION, YOUR ACCUMULATED SERVICE CREDITS UNDER THE PRE-FUNDED PROGRAM WILL BE CANCELLED. IF YOUR ELIGIBILITY IS LATER REINSTATED, YOU MAY EARN NEW SERVICE CREDITS BUT ANY CANCELLED SERVICE CREDITS (THAT WERE PREVIOUSLY LOST) WILL NOT BE RESTORED.**

At the time of your retirement, each eligible service credit you have earned will be applied a service credit rate (as set by the Board of Trustees and subject to change from time to time). The service credit rate will vary depending on your age at retirement. The younger you are when you retire, the lower the service credit rate is because you will be benefiting from the program for a longer period of time than a Participant who retires at an older age. As of January 1, 2003, the service credit rates are as follows:

| Age* | Service Credit Rate |
|---|---|
| 55 | $6.38 |
| 56 | $6.75 |
| 57 | $7.13 |
| 58 | $7.50 |
| 59 | $7.88 |
| 60 | $8.25 |
| 61 | $8.63 |
| 62 or older | $9.02 |

** Service credit rates are based on your age at retirement and are subject to change.*

When you multiply your total service credits by the applicable service credit rate, the resulting amount is your service credit amount. Your self-payment contribution amount for retiree coverage will be the cost of retiree coverage reduced by your service credit amount.

### Disabled Retired Participants

In the event that you are retired due to a Disability (as defined by the Plan), you will receive retiree coverage under the Plan. Your self-payment contribution amount is calculated the same as for retiree coverage, based on your age at the time of your Disability. However, if you are not yet age 55 at the time of your Disability, the service credit rate applied to your service credits will be the age 55 rate.

### Surviving Spouses

If you are eligible for retiree coverage as a surviving spouse, your self-payment contribution amount is calculated the same as for retiree coverage. However, the amount will be based on the Participant's age and service credits at the time of his or her retirement or death, if sooner. In the event of a Participant's death before age 55, the Plan will use the age 55 service credit rate when calculating the self-payment contribution amount.

### Pre-Fund Program Self-Payment Contribution Examples

*Example 1*

Pat retires at age 62 on June 1, 2003 with 34.25 service credits. As of that date, the monthly cost of providing retiree coverage is $450 and the service credit rate for retirement at age 62 is $9.02. Pat's monthly self-payment contribution is calculated as follows:

| | |
|---|---|
| Service Credit Rate For Retirement At Age 62 | $9.02 |
| Service Credits | x 34.25 |
| Service Credit Amount | $308.94 |
| Monthly Cost Of Retiree Coverage | $450.00 |
| Service Credit Amount | -$308.94 |
| Monthly Self-Payment Contribution Amount | $141.06 |

*Example 2*

Chris retires at age 55 on June 1, 2003 with 16.75 service credits. As of that date, the monthly cost of providing retiree coverage is $450 and the service credit rate for retirement at age 55 is $6.38. Chris' monthly self-payment contribution is calculated as follows:

| | |
|---|---|
| Service Credit Rate for Retirement At Age 55 | $6.38 |
| Service Credits | x 16.75 |
| Service Credit Amount | $106.87 |
| Monthly Cost Of Retiree Coverage | $450.00 |
| Service Credit Amount | -$106.87 |
| Monthly Self-Payment Contribution Amount | $343.13 |

### FUNDED PROGRAM SELF-PAYMENT CONTRIBUTIONS

If you are a participant who retired before January 1, 2003, or you work for an employer that does not participate in the pre-funded program, your monthly self-payment contribution amount is determined under the funded program. The amount of the retiree self-payment contribution is determined by the Trustees and is based on the cost of providing coverage. The cost of providing coverage for Participants Eligible for Medicare is less since Medicare pays benefits first, before the Plan and, therefore, the Plan's payments are less. Therefore, the Plan will look at both the retiree and the retiree's spouse to determine the amount of the monthly self-payment contribution. Once you or your spouse becomes Eligible for Medicare, be sure to notify the Fund Office.

## MAKING YOUR RETIREE COVERAGE SELF-PAYMENTS

Self-payment contributions are required for retiree coverage under the Plan, regardless of how your retiree coverage is funded. If you do not make your self-payment contributions in a timely manner, you will lose eligibility for coverage, **which cannot be reinstated** except by returning to full-time Active employment and meeting the Fund's reinstatement rules.

To assist you in making your self-payment contributions in a timely and consistent manner, the Fund provides for automatic payments. When you are eligible for retiree coverage, you will receive the form necessary to elect that your monthly self-payment contributions be automatically withdrawn from your checking or savings account. The withdrawal will be made on the fourth of each month so that you will continue to be eligible for coverage that month.

If you are currently making monthly self-payment contributions using Self-Payment Coupons, you may receive a discount on your monthly amount if you:

- Elect to have your monthly self-payment contributions automatically withdrawn from your checking or savings account; or
- Make, in advance, one self-payment contribution for an entire year of retiree coverage.

When you begin making self-payment contributions as a retiree, Disabled Participant, or surviving spouse, you will be sent a benefit Eligibility ID card. New Eligibility ID cards are mailed to eligible Participants in December of each year.



**AUTOMATIC PAYMENTS ARE:**

- CONVENIENT SINCE YOU DO NOT HAVE TO WRITE A CHECK AND PAY POSTAGE EACH MONTH. PLUS, IF SELF-PAYMENT CONTRIBUTION RATES CHANGE, THE NEW AMOUNT WILL AUTOMATICALLY BE DEDUCTED. HOWEVER, THE FUND OFFICE WILL INFORM YOU BEFORE ANY CHANGE IN RATES OCCURS.
- COST EFFECTIVE BECAUSE THE TRANSACTION IS ELECTRONIC, WHICH MEANS THERE'S A MINIMAL AMOUNT OF MANUAL INTERVENTION. PLUS, THE FUND SAVES ADDITIONAL MONEY BY NOT HAVING TO PRODUCE AND SEND PAYMENT COUPON BOOKS.

# LIFE EVENTS

IN THIS SECTION >>


WHEN YOU ARE INITIALLY ELIGIBLE 18

GETTING MARRIED 19

GETTING DIVORCED 19

ADDING A CHILD 19

CHILD LOSING ELIGIBILITY 20

WORKING FOR A NON-PARTICIPATING EMPLOYER 20

WORKING OUTSIDE THE FUND'S JURISDICTION – RECIPROCITY 20

TAKING A LEAVE OF ABSENCE 21

TAKING A MILITARY LEAVE 21

- If You Do Not Continue Coverage Under USERRA 22

WHEN YOU ARE OUT OF WORK DUE TO A DISABILITY 22

- Temporary Disability 22
- Permanent Disability 23

IN THE EVENT OF YOUR DEATH 23

WHEN YOU RETIRE 23


Your benefits are designed to adapt to your needs at different stages of your life. However, certain life events, such as marriage, divorce, birth of a child, death, or retirement, can affect your benefit coverage. This section describes how your coverage is affected when different life events occur.

## WHEN YOU ARE INITIALLY ELIGIBLE

When you first become eligible for benefits from the Plan, you must fill out an Enrollment Card. The information is needed by the Fund Office to provide benefits to you. No benefits will be processed by the Fund Office without this information.

This form also includes your beneficiary designation for the Death Benefit provided through the Fund.

It is important to keep this information up to date. It is your responsibility to notify the Fund Office of any changes, including any change in your:

- Marital status;
- Spouse's employment and/or insurance coverage (including Medicare eligibility);
- Dependents, such as the name and birth date of your newborn child;
- Child's student status;
- Address; or
- Beneficiary designation.

If any of the above changes occur, contact the Fund Office for an Enrollment Card.

**WHEN YOU ARE FIRST ELIGIBLE, YOU MUST COMPLETE, SIGN AND DATE AN ENROLLMENT CARD.**

**ALL NEW PARTICIPANTS ARE SUBJECT TO THE PLAN'S PREEXISTING CONDITION PROVISION, SEE PAGE 6.**

**KEEP YOUR FUND OFFICE RECORDS UP-TO-DATE**

**IT IS IMPORTANT THAT YOU KEEP THE FUND OFFICE ADVISED OF YOUR CURRENT ADDRESS *AT ALL TIMES* TO ENSURE THAT YOU RECEIVE ALL INFORMATION REGARDING YOUR BENEFITS. TO UPDATE YOUR RECORDS, CONTACT THE FUND OFFICE AND THEY WILL SEND YOU THE APPROPRIATE FORM.**

## 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 any required information. In addition, if your spouse is eligible for other coverage and does not enroll for that coverage, he or she will not be covered under this Plan.

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. Please note that if your spouse is eligible for other coverage and does not enroll for that coverage, he or she will not be covered under this Plan.

At this time, you may want to consider updating your beneficiary information.

## GETTING DIVORCED

If you and your spouse get divorced, your spouse will no longer be eligible for coverage as a Dependent under the Plan effective as of the date the divorce is final. However, your spouse may elect to continue coverage under COBRA 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 COBRA Continuation Coverage. At this time, you may also want to review your beneficiary designation under the Plan. In general, once you are divorced, stepchildren from your former marriage are no longer covered under the Plan, but may be eligible for COBRA Continuation Coverage, see page 27.

The Fund Office may require 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), if applicable. A QDRO and/or QMCSO may affect your benefit coverage or elections. Contact the Fund Office for a free copy of the Fund's procedures for handling such orders.

## ADDING A CHILD

You can add eligible Dependent children at any time. However, you should contact the Fund Office for the necessary forms immediately after a child is born, becomes your legal responsibility, or adoption proceedings have begun, to assure coverage when needed. If you do not notify the Fund Office in writing within 30 days of your Dependent becoming eligible, your Dependent's coverage will not begin until the first day of the month ***after*** you notify the Fund Office.

In general, your natural born child will be eligible for coverage on the date of birth. If you adopt a child or have a child placed with you for adoption, coverage will become effective on the date of placement as long as you are responsible for health care coverage and your child meets the Plan's definition of a

**IF YOU ARE AN ACTIVE PARTICIPANT, YOU AND YOUR DEPENDENTS ARE ELIGIBLE FOR MEDICAL (INCLUDING PRESCRIPTION DRUG AND TRANSPLANT BENEFITS), DENTAL, AND VISION BENEFITS. IF YOU ARE A RETIRED OR DISABLED PARTICIPANT OR SURVIVING SPOUSE, YOU AND YOUR DEPENDENTS ARE ONLY ELIGIBLE FOR MEDICAL BENEFITS, WHICH INCLUDES PRESCRIPTION DRUG BENEFITS AND TRANSPLANT BENEFITS (IF YOUR DEPENDENT IS UNDER AGE 65). YOU AND YOUR DEPENDENTS MAY ALSO RECEIVE DENTAL AND VISION BENEFITS IF YOU ENROLL AND MAKE THE REQUIRED SELF-PAYMENT CONTRIBUTIONS FOR SUCH COVERAGE.**

**IF YOUR SPOUSE AND/OR DEPENDENT IS COVERED UNDER ANOTHER GROUP MEDICAL OR DENTAL PLAN, YOU MUST REPORT SUCH OTHER COVERAGE TO THE FUND OFFICE. THE AMOUNT OF BENEFITS PAYABLE UNDER THIS PLAN WILL BE COORDINATED WITH SUCH OTHER COVERAGE. IN ADDITION, IF YOUR SPOUSE IS ELIGIBLE FOR OTHER COVERAGE AND DOES NOT ENROLL FOR THAT COVERAGE, HE OR SHE WILL NOT BE COVERED UNDER THIS PLAN.**

**RECIPROCITY EXAMPLE**

**AS OF JUNE 1, 2002, THE FUND'S CONTRIBUTION RATE IS $5.90 PER HOUR. JAKE WORKS 300 HOURS IN A STATE WHERE THE RATE IS $7.40. HE WILL RECEIVE ELIGIBILITY CREDIT FOR 375 HOURS UNDER THE FUND EVEN THOUGH HE ONLY WORKED 300 HOURS BECAUSE THE RATE WAS 25% HIGHER IN THE OTHER STATE. IF THE OTHER STATE HAD A $4.40 PER HOUR CONTRIBUTION RATE, JAKE WOULD ONLY RECEIVE CREDIT FOR 225 HOURS UNDER THIS FUND.**

Dependent child. Stepchildren are eligible for coverage on the date of your marriage. To determine a Dependent's eligibility, you may be asked to provide legal documentation, such as a birth certificate, adoption papers, marriage certificate, guardianship documents, divorce decree, or paternity order.

Covered Dependents **do not** include your grandchildren, unless the Participant is the legal guardian, has legally adopted them, or is in the process of adopting them.

## CHILD LOSING ELIGIBILITY

In general, your child is no longer eligible for coverage when he/she is no longer dependent on you for support or on the child's 19th birthday. However, you may continue coverage for your child after attainment of age 19 if your child is a full-time student. In this instance, coverage may continue up to your child's 25th birthday, provided the required monthly contributions are made. You should notify the Fund Office within 60 days of when your child is no longer eligible for coverage. Your child may elect to continue coverage under COBRA for up to 36 months.

If your Dependent child is under 25, a full-time student and wants to continue coverage under the Plan, he/or she must:

- Be enrolled for at least 12 credit hours per semester (or equivalent) at an accredited school, college, or university; and
- Provide written proof to the Fund Office each semester, trimester, term, or quarter from the school's registrar office verifying his/her enrollment as a student and the number of hours for which he/she is enrolled.

In addition, monthly contributions must be made for your child's coverage. Your child must be enrolled for the spring semester to be covered through the following summer.

If your child is not capable of self-sustaining employment upon attaining age 19 because of a physical handicap or mental Disability, you may continue coverage for that child for as long as your own coverage continues and the child depends on you for the major portion of his or her support. To qualify, your child's Disability must begin before his or her coverage would otherwise end and you must submit to the Trustees proof of the incapacity within 31 days of the date your Dependent attains age 19.

## WORKING FOR A NON-PARTICIPATING EMPLOYER

If you work for a non-participating Employer in the construction industry, your eligibility under this Plan is terminated and your bank of hours is forfeited.

You may again become eligible under the Plan by meeting the Plan's Initial Eligibility or reinstated eligibility requirements see page 4.

## WORKING OUTSIDE THE FUND'S JURISDICTION – RECIPROCITY

The Fund has made arrangements with other Operating Engineers health funds for transfer of Employer contributions to a Participant's home fund. You may not, however, 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). Initial Eligibility can be established only by having 300 hours of contributions reported by an Employer for work performed within the jurisdiction of this Fund. Hours may be prorated depending on contribution rates of out-of-state Funds.

You should contact the Fund Office immediately if you accept work as an Operating Engineer outside Wisconsin.

The Fund Office will provide a Transfer Authorization Form that you should complete and sign. No hours will be transferred unless this form is completed. Do not risk losing your eligibility—sign the form and return it to the Fund Office immediately.

**IF YOU AND YOUR SPOUSE BOTH WORK FOR THE SAME EMPLOYER, YOU AND YOUR SPOUSE ARE ELIGIBLE FOR A COMBINED TOTAL OF 12 WEEKS OF LEAVE DURING A 12-MONTH PERIOD.**

## TAKING A LEAVE OF ABSENCE

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth of a child or placement of a child with you for adoption;
- The care of a seriously ill spouse, parent, or child; or
- Your serious Illness.

A family and medical leave of absence is not granted to care for a parent-in-law.

During your leave, you will maintain medical coverage offered through the Fund, provided that you properly notify your Employer and your Employer continues to make contributions on your behalf. You are eligible for a leave under FMLA if you:

- Have worked for a covered Employer for at least 12 months;
- Have worked at least 1,250 hours during the previous 12 months; and
- Work at a location where at least 50 Employees are employed by the Employer within 75 miles.

The Fund will maintain your prior eligibility until the end of the leave, provided your Employer properly grants the leave under the federal law and makes the required notification and payment to the Fund.

You may be required to provide:

- 30-day advance notice of the leave, if possible;
- Medical certifications supporting the need for a leave; and
- Second or third medical opinions and periodic recertification (at your Employer's expense) and periodic reports during the leave regarding your status and intent to return to work.

**REEMPLOYMENT**

**FOLLOWING YOUR DISCHARGE FROM MILITARY SERVICE, YOU MAY BE ELIGIBLE TO APPLY FOR REEMPLOYMENT WITH YOUR FORMER EMPLOYER IN ACCORD WITH USERRA. SUCH REEMPLOYMENT INCLUDES YOUR RIGHT TO ELECT REINSTATEMENT IN ANY EXISTING HEALTH CARE COVERAGE PROVIDED BY YOUR EMPLOYER.**

Your leave will end on the earlier of your return to work or 12 weeks. If you do not return to work within 12 weeks, you may qualify for COBRA Continuation Coverage (see page 27).

## TAKING A MILITARY LEAVE

If you are inducted into the Armed Forces, you should notify the Fund Office, in writing, and your status will be frozen for the length of your service or five years, whichever is less. Upon your return, you may regain your status in the Fund.

If you are called into military service (active duty or inactive duty training) for up to 31 days, your health care coverage will continue if you make the required self-payment contributions. If you are called into military service for more than 31 days, you may continue your coverage by making the required self-payment contributions for up to 18 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Your coverage will continue to the earliest of the following:

- The date you or your Dependents do not make the required self-payment contributions within 30 days of the due date;
- The date you reinstate your eligibility for coverage under the Plan;
- The end of the period during which you are eligible to apply for Reemployment in accordance with USERRA;
- The last day of the month after 18 consecutive months; or
- The date the Fund no longer provides any group health benefits.

You need to notify the Fund Office in writing when you enter the military. For more information about self-payment contributions under USERRA, contact the Fund Office.

**LOSS OF TIME BENEFITS ARE NOT AVAILABLE TO SALARIED ALUMNI OR NON-BARGAINING UNIT PARTICIPANTS.**

### IF YOU DO NOT CONTINUE COVERAGE UNDER USERRA

If you do not continue coverage under USERRA, your coverage will end immediately when you enter active military service. Your Dependents will have the opportunity to elect COBRA Continuation Coverage.

Upon your discharge from military service, you may apply for Reemployment with your former Employer in accordance with USERRA. Such Reemployment includes the right to elect reinstatement in any health insurance coverage offered by that Employer. According to USERRA guidelines, Reemployment and reinstatement deadlines are based on your length of military service.

The following information outlines the deadlines applicable to your rights to Reemployment and reinstatement of health care coverage. When you are discharged or released from military service that lasted:

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

When you are discharged, if you are Hospitalized or recovering from a Sickness or Injury that was incurred during your military service, you have until the end of the period that is necessary for you to recover to return to work for a Contributing Employer.

If your Employer reports your return to the Fund Office during the USERRA required time period, your eligibility and your Dependents' eligibility will be reinstated on the day you return to work.

If you are seeking work in the jurisdiction of the Fund, but are unable to find work, be sure to notify the Fund Office within the USERRA required time period after your discharge or release from military service. You may be allowed to make self-payment contributions for coverage.

The Fund will maintain your prior eligibility status until the end of the leave, provided your Employer properly grants the leave under the federal law and makes the required notification and payment to the Fund.

## WHEN YOU ARE OUT OF WORK DUE TO A DISABILITY

### TEMPORARY DISABILITY

If you are out of work due to a non-work related Disability, you may receive Loss of Time Benefits. You should notify your Employer and the Fund Office. In addition, if you are out of work due to a work-related Disability, you may be eligible for Workers' Compensation. Contact your local or state Workers' Compensation office.

Your benefits may continue and you may continue to earn credit for hours if you are out of work and receiving Loss of Time Benefits from the Fund or Workers' Compensation benefits. If you are out of work due to a job-related Disability, you must provide the Fund Office with a letter from either your Employer or the Workers' Compensation carrier (or a copy of your Workers' Compensation check). In either case, you will receive credit for up to 25 hours of contributions each week, not to exceed 100 hours per month, up to a maximum of:

- 24 months if you are receiving Workers' Compensation benefits; or
- 26 weeks if you are receiving Loss of Time Benefits.

The Fund may require initial proof of Disability as well as subsequent proof, upon request from the Trustees. The Fund also has the right to require you to submit to a medical examination.

**IF YOU BECOME DISABLED DUE TO AN INJURY THAT IS COVERED BY THE AD&D BENEFIT, YOU MAY ALSO BE ELIGIBLE FOR AN AD&D BENEFIT.**

**SURVIVOR COVERAGE IS AVAILABLE FOR YOUR DEPENDENTS THAT WERE ELIGIBLE FOR COVERAGE AT THE TIME OF YOUR DEATH.**

### PERMANENT DISABILITY

If you are permanently Disabled, you may be eligible for retiree coverage under the Plan, see page 12. The Trustees determine the benefits provided under retiree coverage, which may not necessarily be the same as those provided to Active Participants.

To continue your eligibility for retiree coverage as a Disabled Participant, you must:

- Be eligible for coverage at the time of your Disability; and
- Have been credited with Employer contributions to the Health Benefit Fund for at least:
  - > 3,000 hours in the three consecutive Calendar Years immediately preceding your Disability;
  - > 4,000 hours in the four consecutive Calendar Years immediately preceding your Disability; or
  - > 5,000 hours in the five consecutive Calendar Years immediately preceding your Disability.

In addition, if you are a Non-Bargaining Unit Employee, you must not be receiving wages subject to Social Security taxes from any Employer (to be indicated on a form provided by the Fund Office).

You are considered Disabled by the Fund if you are receiving either a:

- Disability benefit from the Central Pension Fund; or
- Social Security disability awards.

You or any of your Dependents who are eligible **must** enroll for Medicare Parts A and B. If you meet these conditions, you can continue your eligibility for coverage by making self-payment contributions.

## IN THE EVENT OF YOUR DEATH

If you die while eligible for coverage under the Fund, your beneficiary will receive a Death Benefit (and an AD&D Benefit if your death is caused by an Accident). See page 64 for more information about the Death and AD&D Benefits provided by the Plan.

In addition, your Dependents' eligibility for coverage will continue until your bank of hours runs out. At this time your surviving spouse can elect to continue eligibility for benefits by making self-payment contributions for retiree coverage, see page 12.

If your spouse is under age 65 at the time of your death, your spouse's eligibility can be continued until remarriage or until your spouse becomes eligible under another group insurance plan (other than Medicare). If your spouse is age 65 or older at the time of your death, his or her eligibility will continue as long as your surviving spouse makes the required self-payment contributions. Your spouse's eligibility is subject to all the rules of retiree coverage (see page 12).

Your Dependent children will also continue to be eligible for medical benefits until age 19, or age 25 if full-time students, as long as your surviving spouse makes the required self-payment contributions, including any monthly contributions for full-time student Dependent children beyond age 19.

Instead of electing retiree coverage, your spouse and Dependent children may continue coverage for up to 36 months by electing COBRA Continuation Coverage and making the necessary self-payment contributions for such coverage (see page 27).

## WHEN YOU RETIRE

When you retire, you may be eligible to continue retiree coverage under the Plan. See page 12 for more information on continuing coverage as a retiree.

**AT THE TIME YOU RETIRE (OR CHANGE TO DISABILITY STATUS), YOU OR ANY OF YOUR DEPENDENTS WHO ARE ELIGIBLE MUST ENROLL FOR MEDICARE PARTS A AND B.**

# CONTINUING COVERAGE

IN THIS SECTION >>


SELF-PAYMENT CONTRIBUTIONS FOR ACTIVE COVERAGE 24
- Self-Payment Notice 25
- The Rules 25
- Amount Of Self-Payments For Active Coverage 26

COBRA CONTINUATION COVERAGE 27
- Qualifying Events 27
- Notifying The Fund Office 28
- Periods Of Coverage 28
- Loss Of Continued Coverage 28
- Paying For COBRA Continuation Coverage 29

A COMPARISON FOR ACTIVE PARTICIPANTS 29
- A Reminder 29


Generally, there are three ways to continue coverage under the Plan once you do not meet the Plan's eligibility rules:

- Self-payment contributions to continue eligibility for Active coverage (only available to bargaining unit Participants and Fund-Related Operating Engineers who are available for full-time employment within the jurisdiction of the Fund);
- Retiree self-payment contributions to continue eligibility for retiree coverage; or
- COBRA Continuation Coverage.

This section describes how to make self-payment contributions to continue eligibility for active coverage and COBRA Continuation Coverage. For more information on continuing coverage under the retiree program, see page12.

## SELF-PAYMENT CONTRIBUTIONS FOR ACTIVE COVERAGE

If you are a bargaining unit Participant or Fund-Related Operating Engineer who is available for full-time employment within the jurisdiction of the Fund, it is possible that there will be Work Quarters in which you have less than 300 hours and where you have less than 1,200 hours in the last four Work Quarters. If this happens to you, **you will lose your eligibility** for coverage.

**CONTINUING ELIGIBILITY FOR COVERAGE BY MAKING SELF-PAYMENT CONTRIBUTIONS IS ONLY AVAILABLE TO:**

- **BARGAINING UNIT PARTICIPANTS; AND**
- **FUND-RELATED OPERATING ENGINEERS WHO ARE AVAILABLE FOR FULL-TIME EMPLOYMENT WITHIN THE JURISDICTION OF THE FUND.**

**IF YOU DO NOT AGREE WITH THE HOURS REPORTED ON YOUR SELF-PAYMENT NOTICE, RETURN THE RECEIPT, ALONG WITH ANY PAYROLL CHECK STUBS OR OTHER SUPPORTING DOCUMENTATION TO THE FUND OFFICE WITH YOUR PAYMENT.**



However, you may be eligible to continue your coverage by making self-payment contributions or electing COBRA Continuation Coverage. You choose the method you prefer. This section describes how to make self-payment contributions to continue your eligibility for coverage, see page 27 for more information on COBRA Continuation Coverage.

You may make a personal payment to the Fund to continue your eligibility for benefits. These personal payments are called self-payment contributions, and you may make these contributions for up to six consecutive Work Quarters. The self-payment contribution amount depends on the number of hours that you were short of the minimum required and also on the self-payment contribution rate. This rate is set periodically by the Trustees.

You may make self-payment contributions to continue your eligibility as long as you are:

- Immediately available for full-time work as an Operating Engineer for a participating Employer;
- Registered in the "out-of-work book" with Local 139; and
- Available to accept a referral for which you are qualified.

*If you work for a non-participating Employer in the construction industry, you are not allowed to make self-payment contributions and you will lose your eligibility for coverage. However, you may be eligible to elect COBRA Continuation Coverage, as described on page 27.*

### SELF-PAYMENT NOTICE

If you do not have sufficient hours to continue your eligibility for coverage, the Fund Office will mail you a Self-Payment Notice before the beginning of March, June, September, or December. The Self-Payment Notice contains the name of the contractor(s), the month(s) worked, and the number of hours reported to the Fund on your behalf for the most recent Work Quarter. It also indicates the total number of hours you had reported on your behalf for the four most recent Work Quarters.

The amount due is stated on the lower left side of the Self-Payment Notice. Before returning the Notice and the self-payment contribution to the Fund Office, be sure to complete the left side of the Notice and sign it at the bottom. If you do not sign the Self-Payment Notice, it will be returned to you for your signature and your eligibility may be delayed. The payment is due within 15 days from the date of the Notice.

When the Fund Office receives your self-payment contribution, you will be sent a receipt. This receipt will also include your Quarterly Benefit Eligibility ID cards.

### THE RULES

Self-payment contributions are limited in nature and there are rules that apply to them. The following information covers these rules.

- You may make self-payment contributions to continue your eligibility only if you are immediately available for full-time employment as an Operating Engineer with a participating Employer. The Fund will assume that you are not available for work if you have withdrawn from, are suspended from or are not registered in the "out-of-work book" with Local 139.

**SELF-PAYMENT CONTRIBUTION EXAMPLE**

**SAM ELECTS TO MAKE SELF-PAYMENT CONTRIBUTIONS TO CONTINUE HER ELIGIBILITY FOR COVERAGE UNDER THE FUND. AFTER MAKING A QUARTERLY SELF-PAYMENT CONTRIBUTION FOR COVERAGE, SAM BEGINS WORKING FOR A NON-PARTICIPATING EMPLOYER. SAM IS NO LONGER ELIGIBLE FOR COBRA CONTINUATION COVERAGE.**

- Self-payment contributions must be made on time—this means within 15 days of the date on the Self-Payment Notice. The Fund Office mails these Notices quarterly – before the beginning of March, June, September, and December.
- If you **do not** make your self-payment contribution on time, you are not eligible for further self-payment contributions. You may, however, be eligible to continue your coverage by electing COBRA Continuation Coverage, as described on page 27.
- The choice between self-payment contributions and COBRA Continuation Coverage is given only when the first self-payment contribution is required. As explained on page 27, you have 60 days to make your COBRA Continuation Coverage election. Therefore, even if you choose self-payment contributions, you may still elect COBRA Continuation Coverage, as long as that decision is made within the 60-day notification period. After the COBRA Continuation Coverage election period has passed, you are not able to elect COBRA Continuation Coverage.
- If you do not receive either a Quarterly Status Report or a Self-Payment Notice by the first day of the first month of the Eligibility Quarter (March, June, September, December), **it is your responsibility** to contact the Fund Office. You must contact the Fund Office by the 15th of the month or when a self-payment contribution is required, **or you may lose eligibility from the first day of the Eligibility Quarter.**

**AMOUNT OF SELF-PAYMENTS FOR ACTIVE COVERAGE**

The cost of self-payment contributions is determined by the Board of Trustees based on the actual cost to provide coverage. The amount is subject to change.

You may make installment payments if the amount shown on your Self-Payment Notice exceeds one-half of the maximum self-payment contribution. As indicated on the Self-Payment Notice, the first installment is due within 15 days of the date on the Notice. The balance, which is the amount listed on the second Self-Payment Form, is due exactly one month later.

If you choose the two-installment plan, your Eligibility ID card will be mailed after **both** payments have been received by the Fund Office. If the Fund Office is contacted by telephone to verify your eligibility for benefits, the person calling will be advised that a payment is due and has not yet been received.

If you or a member of your family requires Prescription drugs, you may purchase your Prescription drugs at the pharmacy of your choice and submit the paid receipt to the Fund Office for processing. However, please note that you will not receive your Prescription at discounted prices from Preferred Provider pharmacies until you make the required self-payment contribution for coverage.

**YOU ARE ELIGIBLE TO CONTINUE COVERAGE BY ELECTING COBRA CONTINUATION COVERAGE IF YOU EXPERIENCE A QUALIFYING EVENT, SEE PAGE 27.**

**COBRA: CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985**

**IF YOU DO NOT NOTIFY THE FUND OFFICE WITHIN 60 DAYS OF A QUALIFYING EVENT, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA CONTINUATION COVERAGE.**

## COBRA CONTINUATION COVERAGE

When you or your Dependents are no longer eligible for coverage, are not eligible to make self-payment contributions, or are eligible but elect not to make self-payment contributions, you may be able to continue coverage at your own cost. If you retire, become Disabled, or die, it will be to your or your beneficiary's advantage to continue coverage under the retiree program (see page 12).

The choice between self-payment contributions and COBRA Continuation Coverage is given only when the first self-payment contribution is required. You have 60 days to make your COBRA Continuation Coverage election. Therefore, even if you choose self-payment contributions, you may still elect COBRA Continuation Coverage, as long as that decision is made within the 60-day notification period. After the COBRA Continuation Coverage election period has passed, you are not able to choose COBRA Continuation Coverage instead of the Fund's self-payment contributions.

Under COBRA, you or your Dependents may continue health care coverage past the date coverage would normally end. Under certain circumstances, you or your Dependents may make self-payment contributions to continue:

- Medical benefits; or
- Medical, dental, and vision benefits.

The COBRA Continuation Coverage will be identical to the coverage you had under the Plan before the COBRA qualifying event; with the exception that you are *not* eligible to continue coverage for Loss of Time, Death, and AD&D Benefits (or dental and vision benefits if you elect medical benefits only).

If you acquire a new child that meets the Plan's definition of an eligible Dependent (for example, have a newborn child, adopt a child or have a child placed with you for adoption) while your COBRA Continuation Coverage is in effect, you may add the child to your coverage. To have this child added to your coverage, you must provide written notification to the Fund Office within 30 days of the birth, adoption, or placement of a child with you for adoption.

Children born, adopted, or placed for adoption as described above, have the same COBRA rights as a Dependent who was covered by the Plan before the event that triggered COBRA Continuation Coverage. Like all qualified beneficiaries with COBRA Continuation Coverage, these children's continued coverage depends on timely and uninterrupted self-payment contributions on their behalf.

### QUALIFYING EVENTS

You do not have to show that you are insurable for COBRA Continuation Coverage. It is offered to you and/or your dependents if you or your Dependents lose coverage as a result of a qualifying event. Qualifying events include your:

- Termination of employment;
- Reduction in hours;
- Death;
- Eligibility for Medicare;
- Divorce; and
- Child losing Dependent status under the Plan.

**IT'S IMPORTANT TO NOTIFY THE FUND OFFICE OF A QUALIFYING EVENT TO MAINTAIN YOUR COBRA RIGHTS.**

**WHEN YOUR COBRA CONTINUATION COVERAGE ENDS, YOU WILL BE PROVIDED WITH CERTIFICATION OF YOUR LENGTH OF COVERAGE UNDER THE PLAN. THIS MAY HELP REDUCE OR ELIMINATE ANY PREEXISTING CONDITION PROVISION UNDER A NEW GROUP MEDICAL PLAN.**

## NOTIFYING THE FUND OFFICE

You or your Dependent must inform the Fund Office of a divorce or a child losing Dependent status under the Plan within 60 days of the qualifying event. If you do not notify the Fund Office within 60 days of such an event, you and/or your Dependents will lose your right to elect COBRA Continuation Coverage.

Your employer may notify the Fund Office of your termination of employment, reduction in hours, or death. However, it is also your responsibility to notify the Fund Office of these events as well as your entitlement to Medicare coverage, divorce, or child losing Dependent status. To help ensure that you do not suffer a gap in coverage, we urge you or your family to notify the Fund Office of qualifying events as soon as they occur. ***If you do not notify the Fund Office within 60 days of a qualifying event, you will lose your right to elect COBRA Continuation Coverage.***

When the Fund Office is notified that one of these events has occurred, you and your Dependents will be notified as to whether or not you are eligible to elect COBRA Continuation Coverage. Once you receive a COBRA Continuation Coverage notice, you have 60 days to respond if you want to elect COBRA Continuation Coverage. Your Dependents have the option to elect coverage independently from you.

## PERIODS OF COVERAGE

***Coverage continues for 18 months*** if your coverage ends due to your termination of employment or your reduction in hours.

***Coverage continues for 29 months*** if you or one of your Dependents are Disabled when your coverage ends or if you become Disabled within 60 days of the date your coverage ends. To continue coverage for up to 29 months, you must notify the Fund Office of your determination of Disability by the Social Security Administration. If the Social Security Administration subsequently determines that you are not (or are no longer) Disabled, you must notify the Fund Office within 60 days of such determination.

***Coverage continues for 36 months*** if your spouse or other Dependent's coverage ends because of your:

- Eligibility for Medicare;
- Death;
- Divorce; or
- Dependent child no longer meets the definition of an eligible Dependent under the Plan.

## LOSS OF CONTINUED COVERAGE

The period of COBRA Continuation Coverage for you or your Dependents may end if:

- You or your Dependents do not make the required self-payment contributions on a timely basis;
- You or your Dependents become covered under any other group health care plan, including Medicare (provided such plan does not contain any exclusions or limitations with respect to any Preexisting Conditions) after electing COBRA Continuation Coverage; or
- The Fund ceases to provide any group health benefits.

If you lose coverage before your maximum period of COBRA Continuation Coverage, the Fund Office will notify you. Your Dependents may be eligible to continue coverage. Once your COBRA Continuation Coverage ends, it cannot be reinstated.

**BE SURE TO NOTIFY THE FUND OFFICE OF ANY ADDRESS CHANGES.**

### PAYING FOR COBRA CONTINUATION COVERAGE

The Fund Office will notify you of the cost of your COBRA Continuation Coverage when it notifies you of your right to coverage. The cost for COBRA Continuation Coverage is determined by the Trustees on a yearly basis, and will not exceed 102% of the cost to provide this coverage. The cost for extended Disability coverage (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

Your first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day your and/or your Dependents' coverage under the Plan ended. The first payment is due 105 days after the qualifying event. The Fund Office will notify you of the due date for the first payment, subsequent payments are due the first of the month. Coverage will end if the payment is not made within 30 days of the due date.

Typically, COBRA Continuation Coverage ends when you become covered by another Employer who offers a group health plan. However, if you or a Dependent has a Preexisting Condition that is not covered by the group health plan, COBRA Continuation Coverage does not end until the end of the maximum 18- or 36-month period, provided the required self-payment contributions are made, or if earlier, until the other coverage's Preexisting Condition provisions end.

## A COMPARISON FOR ACTIVE PARTICIPANTS

Here is a comparison of your coverage continuation options:

| | Self-Payment Contribution | COBRA Continuation Coverage |
|---|---|---|
| *Eligibility Ends* | August 31, 2003 | August 31, 2003 |
| *Payment Privileges Continue Until* | February 28, 2005 | February 28, 2005 |
| *Coverages* | Medical, dental, vision, loss of time, and death benefits | Medical, dental, and vision benefits<br>**or**<br>Medical only |
| *Cost* | Current contribution rate times number of hours short of eligibility | Cost plus 2% |
| *Election Period* | Self-Payment Notice must be signed and returned to the Fund Office with payment within 15 days of date on Notice. | COBRA Enrollment Card must be submitted to the Fund Office within 60 days. |

## A REMINDER

Remember that if you choose the Fund's self-payment contribution program, you cannot, after 60 days, change your mind and elect COBRA Continuation Coverage instead. And, if you do not make the Fund's **first** self-payment contribution within 15 days, you are not eligible to make further self-payment contributions. However, you still will have 60 days to decide on COBRA Continuation Coverage.

# COMPREHENSIVE MEDICAL BENEFITS

## IN THIS SECTION >>


HOW THE PLAN WORKS 31
- Annual Deductible 31
- Coinsurance 32
- Annual Out-Of-Pocket Maximum 32
- Lifetime Maximum 32
- Usual, Customary and Reasonable Charges 32
- Medically Necessary 32

SPECIAL MEDICAL BENEFIT PROVISIONS 32
- Emergency Room Coinsurance 32
- Preferred Provider Network 33
  - Medicare Eligible Participants 34

COVERED EXPENSES 34
- Hospital Charges 34
- Maternity And Obstetrical Benefits 35
- Outpatient And Out-Of-Hospital Care 35
- Hospice Care Benefits 36
- Home Health Care 37
- Routine Physical Examination Benefits 37
  - For You And Your Spouse 37
  - For Your Dependent Children 38
- Surgical Benefits 38
  - Reconstructive Surgery 38
- Temporomandibular Joint Disorder (TMJ) 39
- Certain Dental Care 39
- Congenital Defect Casting 39
- Speech Therapy 39
- Physical Therapy 39
- Occupational Therapy 39
- Kidney And Cornea Transplants 39
- Mental Health And Substance Abuse Treatment 40
- Infertility Benefits 40
- Diabetic Self-Management Education Benefits 40
- Chiropractic Therapy 40
- Hearing Care Benefits 40
- Injectable Medications 40
- Prescription Drug Benefits 40
  - Generic Equivalents And Brand Name Medications 41
  - Retail Pharmacy Program 41
  - Mail Order Program 41
  - Covered Prescription Drug Expenses 43

IF YOU ARE ELIGIBLE FOR MEDICARE 43
- Active Participants And Their Dependents 43
- All Other Participants 43

COMPREHENSIVE MEDICAL BENEFIT EXCLUSIONS AND LIMITATIONS 44


It is fairly easy to plan ahead for the routine medical costs that occur from time to time. But an unexpected expense or an unusually large one can strain a family's finances. Comprehensive Medical Benefits give the kind of financial protection that makes superior health care possible for you and your family—without putting a strain on your budget. Benefits are paid on a percentage basis rather than a flat-fee basis, which means your coverage is always up to date. As health care costs increase, so will your protection.

**All Active and Retired Participants who have satisfied the eligibility requirements of the Fund, and their covered Dependents, are covered for Comprehensive Medical Benefits.** However, there are some exceptions:

- Maternity and obstetrical are covered only for Active and Retired Participants and their spouses; and
- Congenital defect casting is covered only for Dependent children.

Comprehensive Medical Benefits are designed to provide coverage only for care that is Medically Necessary in the treatment of an Illness or Injury. Therefore, medical treatment for elective Cosmetic Surgery or similar non-Medically Necessary treatment is not covered. If you have any questions, please contact the Fund Office.

The Plan's medical benefits coverage is designed to be comprehensive. But no medical plan, ours included, is designed to reimburse you for every item of family health care expense. Budgetable day-to-day medical expenses, such as routinely used vitamins or non-Prescription medicines are your responsibility. Covered items are not paid in full, but a large portion is paid. For more information on what is not covered under the Plan, see page 66.

**AN ANNUAL DEDUCTIBLE IS A DOLLAR AMOUNT THAT MUST BE PAID EACH YEAR BEFORE THE PLAN BEGINS PAYING BENEFITS.**

## HOW THE PLAN WORKS

Comprehensive Medical Benefits pay for a wide range of services and supplies, including Hospital charges, Physician charges, diagnostic testing, and surgery. How the Plan works is simple. Each year between January 1 and December 31, the Plan pays medical benefits like this:

- You are responsible for meeting your annual deductible.
- Once you or your family meets the annual deductible, the Plan pays a percentage of Covered Expenses and you pay the rest. This is known as coinsurance. The coinsurance percentage the Plan pays varies depending on whether you use a Preferred Provider or non-Preferred Provider.
- Once the coinsurance amounts you pay for Covered Expenses, **not** including the amounts you paid toward your annual deductible, reach the annual out-of-pocket maximum, the Plan pays 100% of Usual, Customary and Reasonable (UCR) charges for Covered Expenses incurred for the remainder of that Calendar Year.

Note that some benefits and expenses may be covered differently or subject to benefit maximums. See the *Summary Of Benefits* (in the back pocket of this booklet) and specific benefit descriptions for more information.

### ANNUAL DEDUCTIBLE

The annual deductible is the amount of Covered Expenses that you pay each Calendar Year before the medical and Prescription drug program begins to pay benefits. Payments toward the individual deductible are limited to a family maximum; so that once payments toward the individual deductible for all family members reach the family maximum, individual deductibles for all family members will automatically be satisfied for that year. If only two individuals are covered under the Plan, the family maximum is twice the amount of the individual deductible. It is possible to meet the family maximum without satisfying the individual deductible.

*Annual Deductible Family Maximum Example*

*Dan, his wife Debbie, and their three daughters are covered under the Plan. In January, Dan and one of his daughters each incur $200 in Covered Expenses, these amounts are applied to their individual deductible as well as to the family maximum. In February, Dan's other two daughters each incur $250 in Covered Expenses, these amounts are applied to their individual deductible as well as to the family maximum. While no one in Dan's family has met their individual deductible, since the family has paid $900 in Covered Expenses ($200 + $200 + $250 + $250), Dan's family met the family maximum and no further deductibles will apply for the remainder of the year.*

**AMOUNTS YOU PAY FOR MEDICAL AND PRESCRIPTION DRUG EXPENSES APPLY TOWARD YOUR ANNUAL DEDUCTIBLE. HOWEVER, ONLY AMOUNTS THAT YOU PAY FOR MEDICAL EXPENSES APPLY TOWARD MEETING YOUR ANNUAL OUT-OF-POCKET MAXIMUM; AMOUNTS YOU PAY FOR PRESCRIPTION DRUG BENEFITS DO NOT APPLY. THE FOLLOWING AMOUNTS ARE NOT USED TO SATISFY YOUR ANNUAL DEDUCTIBLE OR OUT-OF-POCKET MAXIMUM:**

- **DENTAL EXPENSES;**
- **VISION EXPENSES,**
- **EXPENSES IN EXCESS OF THE USUAL, CUSTOMARY AND REASONABLE CHARGE;**
- **NON-COVERED EXPENSES; AND**
- **ADDITIONAL EMERGENCY ROOM COINSURANCE AMOUNTS.**

The amounts you pay toward the annual deductible do not apply toward meeting the Plan's annual out-of-pocket maximum.

### COINSURANCE

Coinsurance is the percentage of charges you are responsible for paying for certain covered health services after you meet your annual deductible.

### ANNUAL OUT-OF-POCKET MAXIMUM

The annual out-of-pocket maximum limits the amount of Comprehensive Medical Benefit Covered Expenses you pay each year. The amount of this maximum is listed on the *Summary Of Benefits* (in the back pocket of this booklet). Once you or one of your Dependents meet the per person annual out-of-pocket maximum, 100% of that individual's Comprehensive Medical Benefit Covered Expenses will be paid for the remainder of the Calendar Year. If your family reaches the family maximum, 100% of your and your eligible Dependents Comprehensive Medical Benefit Covered Expenses will be paid for the remainder of the Calendar Year.

### LIFETIME MAXIMUM

While covered under the Plan, Comprehensive Medical Benefits are paid up to the Lifetime maximum specified on the *Summary Of Benefits* (in the back pocket of this booklet). This maximum applies to all expenses incurred under the Plan's Comprehensive Medical Benefits, including Prescription Drug Benefits, from the later of:

- January 1, 2001; or
- The date you first become covered under the Plan.

Transplant Benefits have a separate Lifetime maximum that is not included in the Comprehensive Medical Benefits Lifetime maximum.

### 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 most frequently charge for the same service or procedure in your geographic area. The Plan determines UCR. For a definition of Usual, Customary and Reasonable Charges see page 104.

### MEDICALLY NECESSARY

The Plan pays benefits only for services and supplies that are Medically Necessary. For a definition of Medically Necessary, see page101.

## SPECIAL MEDICAL BENEFIT PROVISIONS

### EMERGENCY ROOM COINSURANCE

In the event of an emergency, there are several treatment alternatives including going to a Physician's office, visiting an urgent care facility, or going to a Hospital emergency room. In many instances when immediate attention is needed, the same level of quality care can be received at a Physician's office or urgent care facility as in a Hospital emergency room – and generally, that care will cost less.

To encourage you to seek less costly, yet quality care, elsewhere, you will be required to pay an additional emergency room coinsurance (as specified on the *Summary Of Benefits* in the back pocket of this booklet) per visit when you go to a Hospital emergency room. This coinsurance percentage is in addition to any other coinsurance amount you are responsible for paying and is not applied toward meeting your annual out-of-pocket maximum amount. However, if you are admitted to the Hospital as a result of your emergency room visit, you are not responsible for payment of the additional coinsurance amount.

The most important consideration in the event of an emergency is to get medical care, especially in a life-threatening situation. However, to ensure you get the most of your health care benefits, find out what your Physician's hours and emergency procedures are and locate the urgent care facility nearest you.

**IT'S ALWAYS A GOOD IDEA TO VERIFY THAT YOUR PROVIDER IS STILL PART OF THE PPO NETWORK BEFORE RECEIVING CARE. TO FIND OUT IF A PROVIDER PARTICIPATES IN THE PLAN'S PPO NETWORK, CALL THE PPO PROVIDER DIRECTLY OR VISIT THEIR WEB SITE. SEE THE *IMPORTANT CONTACT INFORMATION* INSERT FOR THE PHONE NUMBER AND WEB SITE ADDRESS.**

Emergency Room Coinsurance Example

John, an Active employee's son, falls and breaks his toe. John is taken to a Preferred Provider Hospital's emergency room. John's family will have to pay 15% of Covered Expenses – that's 5% of Preferred Provider Hospital Covered Expenses plus an additional 10% (up to a maximum of $200). If John's family had taken him to his Physician's office, they would only have paid 10% (since the Plan pays 90% of Preferred Provider Physician charges) – and the Physician's expenses would probably be much less than the emergency room expenses.

Please note that if John goes to a non-Preferred Provider Hospital, John's family will have to pay 30% of Covered Expenses – that's 20% of non-Preferred Provider Hospital Covered Expenses plus the additional 10%.

If John's fall had been more serious and required Hospitalization, John's family would only have to pay 5%, since the Plan pays 95% of Preferred Provider Hospital Covered Expenses and they would not be subject to the additional 10% emergency room coinsurance.

Please Note: This example assumes John and his family have met the annual deductible and uses the coinsurance percentages in effect as of January 1, 2003. Coinsurance percentages are subject to change. See your most recent *Summary Of Benefits* (in the back pocket of this booklet ) for the current rate or contact the Fund Office.

### PREFERRED PROVIDER NETWORK

To help manage certain health care expenses, the Plan contains a cost management feature – the Preferred Provider Organization (PPO) network. The Fund has contracted with a PPO network to provide benefits to our Participants.

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, you save money for yourself and the Plan because Preferred Providers have agreed to charge a reduced amount for their services.

Most provider networks are big enough to provide just about any type of health care service that you and your family will need. However, we 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 Provider feature of our Plan accommodates these circumstances. Each time you receive medical care, you can choose whether or not to use a Preferred Provider. However, remember that to encourage you to use Preferred Providers whenever possible, the Plan pays a higher percentage of your health care expenses when you go to a 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 Eligibility ID card at the time that you receive services. Finding a Preferred Provider is easy, you can request a provider directory from the Fund Office or, for the most up-to-date information, you can ask your provider if he/she participates in the PPO network or contact the PPO directly- by phone or by visiting their Web site. See the *Important Contact Information* insert to this booklet.

### PREFERRED OR NETWORK PROVIDER

**A NETWORK OF PROVIDERS, INCLUDING PHYSICIANS, HOSPITALS, AND OTHER HEALTH CARE PROFESSIONALS, THAT HAVE AGREED TO CHARGE NEGOTIATED, REDUCED RATES. SINCE PREFERRED PROVIDERS HAVE AGREED TO THESE NEGOTIATED RATES, YOU HELP CONTROL HEALTH CARE COSTS FOR YOU AND THE PLAN WHEN YOU USE PREFERRED PROVIDERS.**

**SEE THE *SUMMARY OF BENEFITS* (IN THE BACK POCKET OF THIS BOOKLET) FOR THE COINSURANCE AMOUNTS PAID FOR PREFERRED PROVIDERS AND NON-PREFERRED PROVIDERS.**

**IF YOU ARE A RETIREE ELIGIBLE FOR MEDICARE, THE PLAN PAYS BENEFITS AS LISTED ON THE *SUMMARY OF BENEFITS* (IN THE BACK POCKET OF THIS BOOKLET), REGARDLESS OF WHETHER OR NOT YOU USE A PREFERRED PROVIDER.**

### Medicare Eligible Participants

There are no PPO provider networks that provide discounts to those whose primary insurance is Medicare. Medicare places restrictions on health care providers by determining a Medicare Approved Amount (the maximum amount Medicare will pay). Generally, this amount is the same or less than the amount that a PPO provider negotiates with its Preferred Providers.

Therefore, if you or one of your Dependents are Eligible for Medicare, the Plan pays benefits as listed on the *Summary Of Benefits* (in the back pocket of this booklet), regardless of whether or not you use a Preferred Provider.

## COVERED EXPENSES

The Plan's Comprehensive Medical Benefits cover Usual, Customary and Reasonable Charges for Medically Necessary treatment, services, and supplies, subject to any Plan maximums. See the *Summary Of Benefits* (in the back pocket of this booklet) for the percent payable by the Plan and any specific Plan maximums. The following information describes the specific coverage provided.

The Fund's medical benefits are coordinated with Medicare. If you are Eligible for Medicare, unless you are an Active Participant or the Dependent of an Active Participant, you **must** enroll for both Medicare Parts A and B. In general, this coordination with Medicare provides you with at least the benefit amount you would receive if you had only the Fund's Comprehensive Medical Benefits. See page 79 for a detailed explanation of how the Fund's benefits are coordinated with Medicare.

### HOSPITAL CHARGES

While you or your Dependents are Confined in a Hospital (inpatient), the Plan covers the following Medically Necessary benefits if they are ordered by a Physician for the condition for which you are admitted:

- Inpatient Physician services with a limit of one treatment by a Physician per day for a single diagnosis, or one treatment for multiple diagnoses within the same medical specialty (except for newborns);
- Semiprivate Hospital room and board charges or charges for a private room if Medically Necessary because the patient has a contagious disease or to prevent possible infection after surgery;
- Intensive Care Unit;
- Special diets;
- General nursing services;
- Operating, delivery, and treatment rooms and equipment;
- Federal legend drugs and medications;
- Dressings, ordinary splints, and plaster casts;
- Laboratory and x-ray examinations;
- Electrocardiograms;
- Basal metabolism tests;
- Physical Therapy;
- Speech therapy;
- Occupational Therapy;
- Oxygen and its administration;
- Anesthetic and its administration;

**COORDINATION OF BENEFITS**

**ALL COMPREHENSIVE MEDICAL BENEFITS ARE COORDINATED WITH BENEFITS UNDER OTHER HEALTH PLANS, INCLUDING MEDICARE. SEE THE EXPLANATION ON PAGE 78.**

**BENEFITS PAID WHERE A THIRD PARTY MAY BE LIABLE**

**THE FUND MAY MAKE A CLAIM AGAINST A THIRD PARTY FOR COMPREHENSIVE MEDICAL BENEFITS WHERE EXPENSES ARE PAID AS A RESULT OF AN ILLNESS, INJURY OR DEATH CAUSED BY ANOTHER PERSON. SEE PAGE 84 FOR A DETAILED EXPLANATION.**

- Administration of blood and blood plasma;
- Intravenous injections and solutions;
- X-ray and radium therapy;
- Radioactive isotope therapy;
- Chemotherapy; and
- Diagnostic services.

### MATERNITY AND OBSTETRICAL BENEFITS

Benefits for maternity care are provided only for you or your eligible spouse (other Dependents are not covered). This Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a Physician to obtain authorization from the Plan for prescribing a length of stay not in excess of these periods. In addition, the Plan covers one pediatrician visit in the Hospital after birth, unless a medical diagnosis is made.

Even though your Dependent female child is not eligible for maternity and obstetrical benefits, the Plan **may** provide benefits for Complications of Pregnancy. Complications of Pregnancy include:

- Acute nephritis;
- Nephrosis;
- Cardiac decompensation;
- Missed abortion;
- Hyperemesis gravidarum;
- Eclampsia of pregnancy;
- Other pregnancy-related conditions that are as medically severe as the above;
- Ectopic pregnancy; and
- Miscarriage or spontaneous abortion where a live birth is not possible.

The following conditions **are not** considered to be Complications of Pregnancy:

- False labor;
- Occasional spotting;
- Rest during pregnancy, even if prescribed by a Physician;
- Elective Cesarean section or a Cesarean section required because a previous pregnancy was terminated by Cesarean section;
- Similar conditions not medically termed as Complications of Pregnancy; and
- Elective abortions.

### OUTPATIENT AND OUT-OF-HOSPITAL CARE

You and your eligible Dependents are covered for care you receive outside the Hospital, in an Ambulatory Care Center or from a Hospital as an outpatient. This means you have protection against expenses for sudden and serious medical problems. Coverage includes reasonable Hospital charges that are Medically Necessary for the treatment of an Illness or Injury.

Medically Necessary outpatient and out-of-Hospital services and supplies covered by the Plan include:

- Treatment by a Physician or surgeon;
- Services of a graduate or licensed nurse (RN) other than assisting at surgery, Certified Registered Nurse Anesthetist (CRNA), Physician Assistant (PA), or Physiotherapist (this does not include a massage therapist, Physical Therapy Assistant (PTA), member of your immediate family, or person ordinarily living in your home);
- Surgical dressings, ordinary splints, plaster casts, braces, and crutches, excluding diabetic supplies, which are covered under the Plan's Prescription drug benefits;
- Laboratory examinations, chemotherapy, anesthesia and its administration, blood and blood plasma, oxygen and its administration, artificial limbs and eyes (as Medically Necessary), artificial breast(s) following mastectomy, and replacements of artificial breast(s), see page 38;

**AS SOON AS YOU KNOW THAT YOU MAY NEED TO USE DURABLE MEDICAL EQUIPMENT, CALL THE FUND OFFICE TO FIND OUT IF IT IS BETTER TO BUY OR RENT. DO NOT WAIT UNTIL AFTER YOU HAVE ALREADY RENTED OR BOUGHT THE EQUIPMENT TO MAKE THE CALL. PURCHASES OF DURABLE MEDICAL EQUIPMENT MUST BE APPROVED.**

- X-ray, radium, or cobalt treatment, including the services of a radiologist and the rental, but not purchase, of such radioactive materials. However, such treatment must be rendered to the Eligible Person in the radiologist's office or in the outpatient department of the Hospital making the charge;
- Charges for local professional ambulance service between Hospitals, as well as to and from the Hospital if transportation is Medically Necessary for proper treatment. Benefits are not payable for transportation or transfer based solely on convenience or personal preference, or for any reason other than Medical Necessity;
- Costs of home care treatment for hemophilia, including blood products and related peripheral materials, such as tourniquets, needles, and syringes (this does not include expenses for a freezer for storage of supplies or for personal service fees for self-infusion);
- Pregnancy tests, when performed by your Physician, for the Participant and spouse only;
- Immunizations and inoculations as Medically Necessary and consistent with accepted medical standards;
- Treatment for damage to sound, natural teeth within six months of an Accident;
- Orthopedic inserts and shoes that must be modified to be attached to a brace when prescribed by a orthopedist and custom made;
- The initial cost of prosthetics or replacement prosthetics when Medically Necessary and **only with prior written approval from the Fund**; and
- Rental (or purchase if the Fund determines this is more cost efficient) of Durable Medical Equipment such as a wheelchair, Hospital bed, and other prescribed Durable Medical Equipment up to the Usual, Customary and Reasonable Charge purchase price and **only with prior written approval from the Fund.**

### HOSPICE CARE BENEFITS

An alternative type of care for the terminally Ill, referred to as Hospice care, allows the patient to receive appropriate care in the most comfortable, home-like atmosphere possible. An individual is considered terminally Ill if he/she has a life expectancy of less than six months, as certified in writing by a Physician. When it is medically determined that an Eligible Person is terminally Ill, the Eligible Person (or authorized representative, such as a family member) and the Physician may prefer Hospice care as opposed to Hospital Confinement.

Benefits are for the period during which the Eligible Person would otherwise, upon recommendation of his or her Physician, have to be Hospital-Confined. Such benefits are payable for home care administered under an approved Hospice Program or Home Health Care Agency at the patient's home, or for care in a Hospice unit of a Hospital or a separate Hospice facility.

Covered Hospice services, provided through a Hospice facility, include:

- Physicians' visits;
- Room and board (if care is not provided in your home or a Hospital);
- Care provided by skilled nurses (RNs) and home health care aides;
- Assessment visits by a Hospice Program staff member; and
- Physical, Occupational, speech, and respiratory therapy.

In the event the medical determination is made that the terminal condition is reversed, benefits are payable as provided under other sections of the Plan.

**HOSPICE BENEFITS DO NOT INCLUDE PATIENT OR FAMILY COUNSELING.**

**YOU CAN NOT GO TO YOUR OWN PHYSICIAN AND USE THE HEALTH DYNAMICS PROGRAM; YOU MUST CHOOSE ONE OR THE OTHER.**

## HOME HEALTH CARE

Home health care recognizes that the use of the patient's own home as an aid in treatment is often beneficial. Home health care is designed for Hospital patients who do not need all Hospital facilities, but would stay Hospitalized without home care.

With the agreement of your Physician, you may be discharged from the Hospital sooner than usually would be expected if you have Home Health Care. All of the services you might need in the Hospital are provided in your home. Your Physician always has complete medical supervision of your case.

The visiting nurse carries out your Physician's orders, provides general nursing services, gives medications and drugs that otherwise would have been given in the Hospital, reports on your condition and progress, and instructs your family regarding your care.

## ROUTINE PHYSICAL EXAMINATION BENEFITS

The Plan covers routine physical examinations for you and your eligible Dependents. Benefits for you and your spouse are different than those for your eligible Dependent children, refer to the *Summary Of Benefits* (in the back pocket of this booklet) for the percent paid by the Plan and specific benefit maximums.

### For You And Your Spouse

The Plan covers an annual physical examination for you and your spouse. You have the choice of going to your own Physician or using the Health Dynamics Program. If the exam is performed by your Physician in his or her office or a Hospital, the Plan covers the exam, laboratory tests, x-rays, mammograms, pap smears, and prostate exams (PSA).

If your annual exam is provided through the Health Dynamics Program, the Plan pays 100% of expenses relating to your physical. You **can not** go to your own Physician and use the Health Dynamics Program; you must choose one or the other.

### Using Your Own Physician Or The Health Dynamics Program Example

In 2003, Kelly chooses to go to her own Physician for a mammogram and pap smear. For the remainder of the 2003 Plan Year, Kelly can not use the Health Dynamics Program. However, in 2004, Kelly may decide to have an annual exam provided through the Health Dynamics Program, instead of going to her own Physician.

The Health Dynamics Program physical involves two visits:

- First visit, you'll receive:
  - > Health history review;
  - > Blood chemistry analysis;
  - > Body composition;
  - > Resting blood pressure;
  - > Height and weight measurements;
  - > Pulmonary function test;
  - > Strength evaluation;
  - > Flexibility testing;
  - > 12-lead EKG;
  - > Cardiovascular fitness test;
  - > Physician directed examination;
  - > Urinalysis;
  - > Colorectal cancer screening;
  - > Chest x-ray or mammogram;
  - > Pap smear (upon request); and
  - > PSA test.
- Second visit, you'll receive:
  - > Results report booklet; and
  - > Personal consultation.

If you or your spouse choose to receive your exam through the Health Dynamics Program, refer to "Dynamic Health" quarterly newsletter for a listing of provider locations and phone numbers.

### For Your Dependent Children

Physicians recommend periodic office visits for well child care. During the first 24 months of your child's life these occur at frequent intervals. The Plan covers routine physical examinations for your Dependent children as specified on the *Summary Of Benefits* (in the back pocket of this booklet). Benefits for your Dependent child from birth to age 24 months are limited to an aggregate maximum amount; benefits for your children age 24 months and older are limited to a maximum Calendar Year amount. Please note that the Fund allows for one pediatrician visit in the Hospital after birth. Any additional charges for Physician visits while a well newborn is an inpatient are not covered.

## SURGICAL BENEFITS

Comprehensive Medical Benefits cover Medically Necessary surgical procedures. Operative and cutting procedures performed by Physicians, including usual inpatient pre- and post-operative care are covered. Benefits are paid whether covered surgery is performed in a Freestanding Surgical Center or in a Hospital.

The Plan pays surgical benefits based on actual fees charged as long as fees are Usual, Customary and Reasonable Charges, and properly submitted. In some cases, Physicians and Hospitals "unbundle" procedures for billing purposes. Unbundling involves separating procedures into several different steps and billing for each one separately to increase the total amount billed. Regardless of whether a provider bundles or unbundles charges, the Fund will pay benefits based on the actual fees charged.

Surgical Benefits Example

A total hysterectomy should be billed as one surgery. To inflate the bill, a Physician might bill separately for preparation for surgery, removal of the uterus, removal of the ovaries, removal of the fallopian tubes, follow-up visits, and removing the stitches. The Fund will pay benefits for one surgery.

For surgery, benefit payment is based on:

- 150% of Usual, Customary and Reasonable Charges for bilateral procedures;
- 10% of Usual, Customary and Reasonable Charges for a PA assisting in surgery if a resident is not available to assist;
- 20% of Usual, Customary and Reasonable Charges for an MD assisting in surgery;
- 50% of Usual, Customary and Reasonable Charges for multiple surgical procedures, other than evaluation and management services, preformed at the same time by the same provider;
- 125% of Usual, Customary and Reasonable Charges, divided equally between co-surgeons. When two surgeons work together as primary surgeons performing distinct parts of a procedure, each surgeon should report his or her distinct operative work as well as any associated procedures.

Benefits for covered Oral Surgery procedures (defined on page 101) are covered only under the Comprehensive Medical Benefits plan.

### Reconstructive Surgery

Benefits for breast Reconstructive Surgery following a mastectomy will be provided on the same basis as other surgical procedures covered by the Plan and include:

- Reconstruction of the breast on which a mastectomy is performed;
- Reconstructive Surgery on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Physical complications of any stage of mastectomy, including lymphedemas.

Under the Women's Health and Cancer Rights Act of 1998, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain Reconstructive Surgery as outlined above.

**ONCE MAXIMUM RESTORATION OF FUNCTION IS REACHED, THE PLAN DISCONTINUES PAYING FOR SPEECH AND PHYSICAL THERAPY.**



### TEMPOROMANDIBULAR JOINT DISORDER (TMJ)

The Plan covers all Medically Necessary charges related to or caused by Temporomandibular Joint Disorder (TMJ), up to the Usual, Customary and Reasonable Charge amount. There is no maximum amount payable on surgical treatment of TMJ; such care is covered under Surgical Benefits (see previous section). However, non-surgical treatment of TMJ has a Lifetime maximum under the Plan, see the *Summary Of Benefits* (in the back pocket of this booklet). This maximum applies regardless of whether the treatment is rendered by a Physician or a Dentist. Benefits for treatment of temporomandibular joint disorder are only covered under Comprehensive Medical Benefits.

### CERTAIN DENTAL CARE

Oral Surgery (as defined on page 101) and Medically Necessary dental treatment are covered under Comprehensive Medical Benefits if your sound, natural teeth are damaged in an Accident. Treatment must be received within six months of the Accident.

Coverage is also provided for treatment of cleft lip and cleft palate conditions. Covered services include Medically Necessary inpatient or outpatient expenses, including Orthodontics, Oral Surgery and otologic, audiological, and speech/language treatment.

### CONGENITAL DEFECT CASTING

If a physical defect, existing at birth and affecting an eligible Dependent child, is corrected by a cast, the Plan covers the appropriate portion of the expenses for casting.

### SPEECH THERAPY

The Plan pays benefits for speech therapy for a medically proven organic pathology, provided the treatment is:

- Medically Necessary;
- Ordered by a Physician; and
- Provided by a certified therapist.

The certified therapist must be someone other than a spouse, child, brother, sister, brother-in-law, sister-in-law, mother, father, mother-in-law, father-in-law, or a person ordinarily living in your home.

### PHYSICAL THERAPY

The Plan covers Physical Therapy provided in a Hospital, clinic, office, Skilled Nursing Facility, Extended Care Facility, or your home when necessary to restore functions lost or reduced by Illness or Injury.

Physical Therapy must be prescribed and supervised by a licensed Physician and must be administered by a licensed physical therapist. In addition, the therapy must be justified by the Physician's diagnosis and medical recommendation. Physical Therapy administered by a Physical Therapy Assistant (PTA) is not covered.

### OCCUPATIONAL THERAPY

The Plan covers Occupational Therapy, including Physical Therapy administered by an occupational therapist. However, outpatient Occupational Therapy is covered only when it meets the Plan's definition of Physical Therapy and is performed by an occupational therapist.

### KIDNEY AND CORNEA TRANSPLANTS

Comprehensive Medical Benefits cover kidney and cornea transplants for Medically Necessary services, up to the aggregate Lifetime maximum listed on the *Summary Of Benefits* (in the back pocket of this booklet). The individual needing the transplant must have satisfied the eligibility requirements for 12 out of the 24 months preceding the transplant.

Covered services include:

- Hospital room and board (semiprivate room);
- Physicians' services and related inpatient services;
- Acquisition, preparation, removal, transportation, and storage of the kidney or cornea, up to the maximum listed on the *Summary Of Benefits* (in the back pocket of this booklet);
- Transportation, lodging, and meals for the patient only as medically required pre- and post-surgery;
- Diagnostic x-ray and laboratory, etc.; and
- Local ambulance, rental of wheelchair, etc.

**THE PLAN COVERS MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT THROUGH THE EAP, SEE PAGE 46.**

**PLEASE NOTE: PRESCRIPTION DRUG COINSURANCE AMOUNTS APPLY TO THE MEDICAL ANNUAL DEDUCTIBLE BUT NOT THE OUT-OF-POCKET MAXIMUM.**

### MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

Comprehensive Medical Benefits cover inpatient and outpatient treatment for mental health (including mental, nervous, and eating disorders) and substance abuse (including alcoholism and drug abuse) through the Employee Assistance Program (EAP), see page 46. Mental health and substance abuse treatment benefits provided under the EAP are insured under a policy purchased from Health Management Center (HMC). The coverage provided under this policy is summarized in the Employee Assistance Program (EAP) section of this booklet. In addition, a copy of the HMC *Summary of Benefits* booklet is available, free of charge, from the Fund Office.

Treatment must be preauthorized by the EAP and the authorized treatment plan must be followed to be covered, subject to the maximums listed on the *Summary Of Benefits* (in the back pocket of this booklet).

### INFERTILITY BENEFITS

Infertility benefits are covered under the Plan for you and your eligible spouse only. Benefits include Medically Necessary testing and treatments related to the diagnosis of infertility, up to the Lifetime maximum listed on the *Summary Of Benefits* (in the back pocket of this booklet).

### DIABETIC SELF-MANAGEMENT EDUCATION BENEFITS

The Plan provides coverage for diabetic self-management education programs up to the Lifetime maximum specified on the *Summary Of Benefits* (in the back pocket of this booklet), provided the program is Medically Necessary and prescribed by a Physician. Covered Expenses include services such as dietary counseling and training on the proper technique for administration of injections.

### CHIROPRACTIC THERAPY

The Plan covers Medically Necessary treatment received from a licensed chiropractor for spinal manipulation, up to the maximums listed on the *Summary Of Benefits* (in the back pocket of this booklet). Spinal manipulation is care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the body to remove nerve interference and its effect, where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column. Chiropractic therapy includes therapeutic, supportive, and maintenance care.

### HEARING CARE BENEFITS

The Fund provides hearing care benefits up to the maximums listed on the *Summary Of Benefits* (in the back pocket of this booklet) for a hearing exam and hearing aid(s). This benefit may cover the majority of behind-the-ear, in-the-ear, and in-the-canal aides that are available. If you opt for advanced technology, such as completely in-the-canal devices or digitally programmable hearing aids, the Fund's benefit allowance will not cover the full cost.

### INJECTABLE MEDICATIONS

The Plan's medical benefits cover injectable medications except insulin and birth control, which are covered under the Plan's Prescription drug benefits.

### PRESCRIPTION DRUG BENEFITS

Prescription drug expenses are rising faster than most other health care expenses, and can be a significant expense for you and your family. Recognizing this, the Fund offers Prescription drug benefits to you and your eligible Dependents. Prescription drug benefits are offered through a Pharmacy Benefit Manager, which includes a network of participating pharmacies (Preferred Provider pharmacies) and a mail order program. While you can go to any retail pharmacy and have your Prescription filled, when you have your Prescriptions filled at a Preferred Provider retail pharmacy or through the mail order program, you save money for yourself and the Plan.

When you need a medication for a short time, it may be easier to go to a retail pharmacy. If you are taking a medication on a long-term basis, it may be more convenient to have it filled through the mail order program because you can get a larger supply through the mail order program.

**A GENERIC EQUIVALENT IS A COPY OF A BRAND NAME MEDICATION THAT IS NO LONGER PROTECTED BY A PATENT. A GENERIC MEDICATION USUALLY SERVES THE SAME PURPOSE AS THE ORIGINAL (BRAND NAME) MEDICATION AND COSTS LESS.**

**THE MAIL ORDER PRESCRIPTION DRUG PROGRAM ALLOWS YOU TO GET UP TO A THREE-MONTH SUPPLY OF A PRESCRIPTION AT ONE TIME.**

Prescription drug benefits are subject to the Comprehensive Medical Benefits annual deductible. However, Prescription drug benefits are not subject to the Plan's out-of-pocket maximum. This means that amounts you pay for Prescription drug expenses count toward meeting your annual deductible but do not count toward meeting your out-of-pocket maximum for Comprehensive Medical Benefits.

### 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.

### Retail Pharmacy Program

The retail pharmacy program is for your short-term Prescription needs, like cold or flu medications. Here's how the retail pharmacy program works:

- When you are eligible for coverage, you receive a Prescription Drug ID card.
- Go to a pharmacy in your area – to receive your Prescription at preferred prices, use a Preferred Provider pharmacy.
- Show your Prescription Drug ID card when you have your Prescription filled.
- Pay for your Prescription at the time you pick it up.
- Submit a claim to the Fund Office for reimbursement.

The Plan will then reimburse you the coinsurance percentage that the Plan pays, as listed on the *Summary Of Benefits* insert to this booklet. However, since Prescription drug benefits are subject to the annual deductible, you must first meet your annual deductible before the Plan begins paying any benefits. If you are over age 65 or Medicare is your primary coverage, you are not subject to the deductible, the Plan begins paying benefits immediately.

### Mail Order 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 PLAN'S PHARMACY NETWORK HAS THOUSANDS OF LOCATIONS NATIONWIDE, INCLUDING MOST MAJOR CHAIN STORES. WHEN YOU GO TO A PREFERRED PROVIDER PHARMACY AND PRESENT YOUR PRESCRIPTION DRUG ID CARD, YOU RECEIVE PREFERRED PRICES ON YOUR MEDICATIONS.**

**IF YOU USE THE MAIL ORDER PROGRAM, YOU WILL NEED TO PAY FOR YOUR PRESCRIPTION WHEN YOU MAIL IT IN. IF YOU ARE NOT PAYING BY CREDIT CARD, YOU WILL NEED TO CONTACT THE PRESCRIPTION BENEFIT MANAGER FOR THE EXACT AMOUNT OF YOUR PRESCRIPTION.**

If your Physician prescribes a long-term medication for you, follow these steps to have your Prescriptions filled (or refilled) through the mail order program:

Step 1: Ask your Physician for a Prescription for up to a three-month supply, plus refills if appropriate.

Step 2: Complete a mail order form, making sure to include all requested information (some of which can be found on your Prescription Drug ID card). If you need additional order forms, contact the Fund Office or the Prescription Benefit Manager (see the *Important Contact Information* insert to this booklet).

Step 3: Complete the health history (it is part of the order form and only needs to be completed the first time you use the mail order program).

Step 4: Send your completed form, along with the written Prescription and your payment, using the pre-addressed, postage paid envelope provided with your order form.

You may charge the full amount of your payment on your VISA, MasterCard, American Express, or Discover Card credit card or you can pay by check or money order.

It will take approximately 10-14 days from the time you send in your order until you receive your Prescription(s). With each delivery, you will receive a new order form and a pre-addressed, postage paid envelope.

If your written Prescription indicates that refills are available, you will receive a refill number with your Prescription order. You then have several options on refilling your Prescription; you can refill your Prescription online, by phone, or by mail. See the *Important Contact Information* insert to this booklet.

**IN GENERAL, YOU MUST PAY THE ENTIRE COST OF YOUR PRESCRIPTION AT THE TIME YOU HAVE IT FILLED. HOWEVER, *IF YOUR COVERED PRESCRIPTION COSTS MORE THAN $1,500,* YOU MAY BE ABLE TO PAY YOUR COINSURANCE PERCENTAGE AND THEN ASSIGN PAYMENT OF THE BALANCE TO THE PLAN. THIS MEANS THAT YOU CAN HAVE THE PROVIDER BILL THE FUND DIRECTLY. THE PLAN WILL THEN REIMBURSE THE PROVIDER THE COINSURANCE PERCENTAGE THAT THE PLAN PAYS. CHECK WITH YOUR PHARMACY OR THE MAIL ORDER PROVIDER TO SEE IF THEY WILL DO SO. IF NOT, YOU MUST PAY THE ENTIRE AMOUNT OF THE PRESCRIPTION AT THE TIME YOU HAVE YOUR PRESCRIPTION FILLED. IN ADDITION, REMEMBER THAT YOU MUST FIRST MEET YOUR ANNUAL DEDUCTIBLE BEFORE THE PLAN BEGINS PAYING ANY BENEFITS.**

**THE PLAN COORDINATES ALL BENEFITS WITH OTHER COVERAGE. IF YOU OR ONE OF YOUR DEPENDENTS ARE ELIGIBLE FOR COVERAGE UNDER MEDICARE, YOU MUST ENROLL IN MEDICARE TO RECEIVE THE MAXIMUM COVERAGE POSSIBLE.**

### Covered Prescription Drug Expenses

Generally, the Plan covers Federal Legend Drugs that require a written Prescription from a Physician or Dentist. A licensed pharmacist must dispense these Prescriptions. The Plan also covers other legend drugs available by Prescription such as:

- Compounded medications of which at least one ingredient is a Prescription legend drug;
- Insulin;
- Insulin syringes/needles and other diabetic supplies such as test strips, test tape, and lancets;
- Fertility agents (for you and your eligible spouse only), such as pergonal and metrodin;
- Prenatal vitamins;
- Immunosuppressant (anti-rejection) drugs;
- AIDS-related drugs; and
- Legend meclizine.

Viagra (or similar such medications) is covered under the Plan's Prescription drug benefits if your Physician provides medical documentation that it is necessary to treat a dysfunction that is organic in nature. You must obtain precertification from the Fund Office before you can have your Prescription filled. In addition, each year you must obtain recertification from the Fund Office to continue to have your Prescription covered under the Plan. If you do not obtain precertification (or recertification, as necessary) from the Fund Office, your Prescription is not covered under the Plan.

The Plan does cover medications related to the treatment of attention deficit disorder. However, if the medication is for an individual over age 14, you must provide medical documentation that the medication is necessary to treat this disorder. If you do not provide this documentation, the Prescription is not covered under the Plan.

## IF YOU ARE ELIGIBLE FOR MEDICARE

### ACTIVE PARTICIPANTS AND THEIR DEPENDENTS

At age 65, you become Eligible for Medicare benefits. As long as you are actively working and have enough hours or make the required self-payment contributions, you continue to be covered by the Fund's medical benefits. The Fund assumes that our medical benefits are your primary coverage (and your Dependent's if also Eligible for Medicare); Medicare benefits will be secondary, if you are enrolled for coverage. This way, you have the benefit of two coverages.

As long as you remain actively at work, you should continue to submit your claims to the Fund. After payment, you can submit the expenses to Medicare for possible payment.

### ALL OTHER PARTICIPANTS

If you are Retired, Disabled, or a surviving spouse, and become Eligible for Medicare, Medicare is your primary coverage. **To receive coverage under this Plan, you and/or your spouse must sign up for both Medicare Part A and Part B** when eligible. This means, if you are Retired and your spouse becomes Eligible for Medicare, even if you are not yet eligible, then your spouse must enroll. The Plan pays benefits after Medicare has covered the expense.

For more information on Medicare and how the Plan coordinates benefits with Medicare, see page 79.

## COMPREHENSIVE MEDICAL BENEFIT EXCLUSIONS AND LIMITATIONS

Comprehensive Medical Benefits provide coverage for most medical expenses related to an Illness or Injury. You should be aware that some expenses are not covered by the Plan. In addition to any *General Plan Exclusions And Limitations* (see page 66), Comprehensive Medical Benefits are not paid for the following expenses.

1. Abortion procedures.
2. Blood donor services.
3. Convenience items provided while you are an inpatient.
4. Dental implants (these may be covered under the Plan's dental benefits).
5. Dental treatment, except as specifically described elsewhere in this booklet.
6. Durable Medical Equipment supplies and repairs, except that repairs to wheelchairs and prosthetics are covered.
7. Education, training, and room and board charges while you or your Dependent is confined in an institution that primarily is a school or other institution for training, a place of rest, a place for the aged, or a nursing home.
8. Maternity services for other than the Participant or legal spouse.
9. Motor vehicles, lifts for wheelchairs, and stair lifts.
10. Non-Prescription medications (also known as over-the-counter medications), vitamins, nutrients, and food supplements, even if prescribed or administered by a Physician.
11. Nursing home care.
12. Prescription Drug Benefit Exclusions:
    a. Administration or injection of any drug (however, this may be covered under the Plan's medical benefits).
    b. Medications:
        i. Betaseron, Avonex.
        ii. Covered Prescription medications that are not self-administered or are administered in a Hospital, long-term care facility or other inpatient setting. However, you may purchase Prescription medications under the Plan and take them to your Physician to be administered.
        iii. Individually packaged medications purchased through or billed by a nursing home or similar facility.
        iv. Non-legend (over-the-counter) drugs other than insulin.
        v. Topical minoxidil (Rogaine).
    c. Therapeutic supplies, devices, or appliances, including support garments and other non-medical substances (unless listed otherwise).
    d. Vitamins, including over-the-counter vitamins or prescribed vitamins, except that pre-natal vitamins are covered.

13. Reconstructive or Cosmetic Surgery, except for Medically Necessary surgery or as specifically listed as covered elsewhere in this booklet.
14. Consultation services related to medical or surgical services when they are rendered by the same Physician during the same Hospital admission, except at the sole discretion of the Plan.
15. Services performed by interns, residents, physician assistants, surgical technicians, or registered nurses who are employees of a Hospital, clinic, or Physician, and whose fees are charged by, for, or payable to a Hospital, clinic, Physician, or other institution. However, services performed by Physician Assistants will be covered if no surgical resident is available on staff.
16. Sterilization reversal procedures, if the Plan paid benefits for the sterilization.
17. Surrogate maternity services.
18. Chelation therapy, except for acute arsenic, gold, mercury, or lead poisoning.
19. Speech Therapy unless you have a medically proven organic pathology.
20. Therapy services, such as recreational, educational, water, music or art therapies, or physical fitness or exercise programs.
21. Topical application form of minoxidil, Rogaine, or their medical equivalent.
22. Transplants, except as specifically listed as covered elsewhere in this booklet.
23. Transportation or travel to or from medical treatment, except as specifically described elsewhere in this booklet.
24. Transsexual operations or any care or services associated with this type of operation.
25. Eye exams or glasses, except as specifically described elsewhere in this booklet.
26. Surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK), Anterior Lens Keratotomy (ALK), and Laser in Situ Keratomileusis (LASIK).
27. Vision therapy and training.
28. Expenses incurred for preventive control programs, such as dietary instruction or educational training.

# EMPLOYEE ASSISTANCE PROGRAM (EAP)

IN THIS SECTION >>


COVERED EXPENSES 46
PREAUTHORIZATION 47
EAP EXCLUSIONS AND LIMITATIONS 47


The Plan provides mental health and substance abuse treatment benefits through an Employee Assistance Program (EAP). The EAP is designed to provide prompt, professional help when you or your Dependents experience personal problems, stress, marital difficulties, and other similar problems. The EAP offers an extensive nationwide network of professional therapists, Hospitals, and alternate care facilities (network providers) to ensure that you and your family receive the highest quality mental health and substance abuse treatment services.

Mental health and substance abuse treatment benefits provided under the EAP are insured under a policy purchased from Health Management Center (HMC). Since HMC is responsible for administering the Plan, you should contact HMC if you:

- Have any questions about your mental health and substance abuse benefits;
- Need preauthorization for mental health and/or substance abuse treatment;
- Need to file a claim for mental health and/or substance abuse benefits; or
- Want to appeal a denied mental health and/or substance abuse claim.

For more detailed information, contact the Fund Office for a free copy of HMC's *Summary of Benefits* booklet.

## COVERED EXPENSES

Benefits provided under the EAP include mental health treatment such as treatment for mental, psychoneurotic, personality, nervous and eating disorders, and substance abuse treatment such as for alcoholism and drug/chemical abuse. Under the EAP, up to the first five visits per person per year for problem evaluation, information, and referral (this does not include MD visits and psychological testing) are covered.

**SEE THE *IMPORTANT CONTACT INFORMATION* INSERT TO THIS BOOKLET FOR MORE INFORMATION ON THE PLAN'S EAP PROVIDER.**

**YOU MUST CALL THE EAP FOR PREAUTHORIZATION BEFORE BEGINNING ANY TREATMENT FOR MENTAL HEALTH OR SUBSTANCE ABUSE. IN THE EVENT OF AN EMERGENCY HOSPITAL ADMISSION, YOU MUST CALL FOR PREAUTHORIZATION WITHIN 48 HOURS AFTER THE ADMISSION.**



After that, mental health and substance abuse treatments will continue to be covered. However, all mental health and substance abuse treatment benefits must be preauthorized by the EAP provider and you must follow the authorized treatment plan or your expenses will not be covered. Once you obtain preauthorization, benefits are paid as shown on the *Summary Of Benefits* insert to this booklet.

You must use a provider that participates in the EAP provider's network. If you use a non-network provider, no benefits are payable under the Plan. However, if no network providers are available in a particular area, or in the event of an emergency, benefits may be payable if you contact the EAP provider and preauthorize your care.

## PREAUTHORIZATION

Before beginning any treatment for mental health or substance abuse you or your Dependent must call the EAP for preauthorization. In the event of an emergency Hospital admission, you must call for preauthorization within 48 hours after the admission.

By preauthorizing your care and treatment plan, you help ensure that you receive the most effective treatment and save money on your health care expenses. If you do not call first **and** follow the authorized treatment plan, your treatment expenses are not covered.

To limit your out-of-pocket expenses for mental health or substance abuse treatment, you should contact the EAP before beginning any treatment and be sure to follow the authorized treatment plan.

## EAP EXCLUSIONS AND LIMITATIONS

You should be aware that some expenses are not covered under the Plan's EAP program. In addition to any *General Plan Exclusions And Limitations* (see page 66), EAP program benefits are not paid for the following expenses.

1. Treatment of detoxification in newborns, except as may be covered under the Plan's Comprehensive Medical Benefits.
2. Treatment of congenital and/or organic disorders, including, but not limited to, organic brain disease and Alzheimer's disease.
3. Treatment of mental retardation, other than the initial diagnosis.
4. Treatment of obesity.
5. Court-ordered testing and treatment if not Medically Necessary.
6. Private Hospital room and/or private duty nursing, unless determined to be Medically Necessary and preauthorized.
7. Ancillary services such as vocational rehabilitation, behavior training, sleep therapy, and employment counseling, training, or educational therapy for learning disabilities or other educational services.
8. Network outpatient, inpatient, and alternate care services in excess of those authorized by the EAP provider.
9. Prescription and non-Prescription drugs, except for medications prescribed by a Physician in connection with treatment as an inpatient at a Hospital.
10. Inpatient services, treatment, or supplies rendered without preauthorization, except in the event of an emergency.
11. Damage to the facility of a network provider caused by an Eligible Person. The actual cost of such damage may be billed directly to the Eligible Person.
12. Experimental health care services, treatment, or supplies.
13. Treatment, care, services, or supplies as a result of any Workers' Compensation law or similar legislation obtained through, or required by, any governmental agency or program, whether federal, state, or any subdivision or caused by the conduct or omission of a third party for which the Eligible Person has a claim for damages or relief, unless the Eligible Person provides the EAP provider with an agreement to reimburse the EAP provider.
14. Treatment, care, services, or supplies for military service disabilities for which treatment is reasonably available under a governmental health care program.
15. Treatment, care services, or supplies that are primarily for rest, Custodial, domiciliary, or convalescent care.

# TRANSPLANT BENEFITS
## EXCEPT KIDNEY & CORNEA

IN THIS SECTION >>


| | |
|---|---|
| BENEFIT PERIOD | 49 |
| COVERED EXPENSES | 49 |
| BENEFIT MAXIMUMS | 52 |
| PROCEDURES SCHEDULED BUT NOT PERFORMED | 53 |
| EXTENDED TRANSPLANT BENEFITS | 54 |
| PREEXISTING CONDITIONS | 54 |
| TRANSPLANT BENEFIT EXCLUSIONS AND LIMITATIONS | 54 |


Transplants are very expensive medical procedures. To help you receive the care you need and, at the same time, to help you and the Plan manage the cost of transplants, the Plan has a separate insured program to cover Transplant Benefits. Kidney only transplants and cornea transplants are covered by the Comprehensive Medical Benefits, see page 39.

This section is a summary of the insured program of benefits; exact terms of the coverage are included in the insurance contract, which is available upon request from the Fund Office. In addition, coverage under this benefit is subject to change.

The Plan's Transplant Benefits includes:

- Organ Transplants: The Plan covers liver, heart, heart/lung, lung (single and double), pancreas, pancreas/kidney, and small intestine transplants. Kidneys are only covered under the Plan's Transplant Benefits when a combined pancreas and kidney transplant procedure is performed.

**THE FUND PROVIDES TRANSPLANT BENEFITS FOR ALL ELIGIBLE PARTICIPANTS WHO ARE NOT ELIGIBLE FOR MEDICARE. HOWEVER, THE INDIVIDUAL NEEDING THE TRANSPLANT IS SUBJECT TO A PREEXISTING CONDITION PROVISION, SEE PAGE 6.**

**THE PLAN PROVIDES COVERAGE FOR ORGAN AND BONE MARROW TRANSPLANT SURGERIES, INCLUDING (BUT NOT LIMITED TO):**

- **LIVER;**
- **HEART;**
- **HEART/LUNG;**
- **LUNG;**
- **PANCREAS;**
- **PANCREAS/KIDNEY;**
- **SMALL INTESTINES; AND**
- **BONE MARROW**

**KIDNEY AND CORNEA TRANSPLANTS ARE COVERED UNDER THE PLAN'S COMPREHENSIVE MEDICAL BENEFITS.**

- Bone Marrow Transplants: The Plan covers the following bone marrow transplant procedures to treat leukemia, lymphoma, blood and genetic diseases, or solid tumors:
  - > Allogeneic;
  - > Autologous, including autologous bone marrow transplant in breast cancer and testicular cancer;
  - > Syngeneic; and
  - > Peripheral stem cell.

  However, these procedures are not covered if they are used as a treatment for, or used as a method of, immune reconstitution for individuals infected with any human T-cell viruses.
- Circulatory Assist Devices: The Plan covers medical expenses incurred by registered candidates during the circulatory assist device benefit period.
- Hepatic Assist Devices: The Plan covers medical expenses incurred by registered liver candidates during the hepatic assist device benefit period.

## BENEFIT PERIOD

Expenses relating to Transplant Benefits are covered during the applicable "benefit period" as follows:

- Organ Transplant Benefit Period: The organ transplant benefit period is 370 continuous days and begins five days before the covered organ transplant procedure.
- Bone Marrow Transplant Benefit Period: The bone marrow transplant benefit period is 395 continuous days and begins 30 days before a covered bone marrow transplant infusion.
- Circulatory Assist Device Benefit Period: The circulatory assist device benefit period begins five days before the circulatory assist device implant and ends on the date of a covered heart or heart/lung transplant procedure. If the procedure is not completed, the circulatory assist device benefit period will end on the date of the intended recipient's death or the date of explant of the circulatory assist device, whichever occurs first.
- Hepatic Assist Device Benefit Period: The hepatic assist device benefit period begins five days before the hepatic assist device implant and ends on the date of a covered liver transplant procedure. If the procedure is not completed, the hepatic assist device benefit period will end on the date of the intended recipient's death or the date of explant of the hepatic assist device, whichever occurs first.

## COVERED EXPENSES

Benefits are payable only if two board certified specialists in the field of surgery provide written notice certifying that alternative procedures, services, or courses of treatment would not be effective for the patient's condition.

Participants who wish to donate an organ (e.g., bone marrow) are not covered, because of lack of Medical Necessity. However, if a Participant requires a covered organ, the Plan covers the costs of the Participant and the donor. In such circumstances, the donor is covered for only those medical services related to the transplants.

**COORDINATION OF BENEFITS**

**ALL TRANSPLANT BENEFITS ARE COORDINATED WITH BENEFITS UNDER OTHER HEALTH PLANS. SEE THE EXPLANATION ON PAGE 78.**

**BENEFITS PAID WHERE A THIRD PARTY MAY BE LIABLE**

**THE FUND MAY MAKE A CLAIM AGAINST A THIRD PARTY FOR TRANSPLANT BENEFITS WHERE EXPENSES ARE PAID AS A RESULT OF AN ILLNESS, INJURY, OR DEATH CAUSED BY ANOTHER PERSON. SEE PAGE 84 FOR A DETAILED EXPLANATION.**

Covered medical expenses are those incurred during the applicable benefit period that:

- Result from or are directly related to the completion of a covered transplant procedure or assist device;
- Are related to the condition, Illness, or disease that necessitated the covered transplant procedure or assist device;
- Are related to complications resulting from the condition, Illness, or disease that necessitated the covered transplant or assist device; and
- Are complications resulting from the covered transplant procedure or assist device itself.

The following Transplant Benefit expenses are covered under the Plan:

- Hospital services, including:
  - > Room, board, and general nursing service in a room with two or more beds or a bed in a special care unit;
  - > Ancillary Hospital services and supplies, including, but not limited to:
    - > Use of operating and treatment rooms;
    - > Prescribed drugs;
    - > Whole blood, administration of blood, and blood processing;
    - > Anesthesia, anesthesia supplies, and services rendered by an employee of the Hospital or facility;
    - > Medical and surgical dressings and supplies;
    - > Diagnostic services; and
    - > Therapy services, such as radiation therapy, chemotherapy, and dialysis treatment.
  - > Outpatient surgery Hospital services and supplies, including removal of sutures, anesthesia, anesthesia supplies, and services rendered by an employee of the Hospital or facility other than the surgeon or assistant at surgery; and
  - > Pre-admission testing, including tests and studies required in connection with admission or outpatient treatment prior to a scheduled admission.
- Surgical and medical services including:
  - > Surgical services performed by a Physician or other professional provider (provided separately for pre- and post-operative services);
  - > Surgical assistant, provided an intern, resident, or house staff member is not available;
  - > Administration of anesthesia ordered by the attending Physician and rendered by a Physician or other professional provider other than the surgeon or assistant surgeon;
  - > Second surgical opinions for a consulting opinion and related diagnostic services to confirm the need for recommended surgery, provided the Physician who originally recommended surgery does not provide the second (or third) opinion (a third opinion and directly related diagnostic services are covered in the event the second opinion conflicts with the original recommendation).

- Inpatient medical services by a Physician or other professional provider for a condition related to the transplant procedure or complication related to the transplant procedure, including inpatient medical care visits, intensive medical care, concurrent care, and consultation.
- Outpatient medical services rendered by a Physician or other professional provider for a condition directly related to the transplant, including emergency medical care and home, office, and other outpatient visits.
- Outpatient diagnostic services, including:
  - > Radiology, ultrasound, and nuclear medicine;
  - > Laboratory and pathology; and
  - > ECG, EEG, other electronic diagnostic medical procedures, and physiological medical testing.
- Outpatient therapy services, including:
  - > Radiation therapy;
  - > Chemotherapy;
  - > Dialysis treatment for 30 days after discharge from the Hospital (in any setting);
  - > Physical Therapy;
  - > Occupational Therapy;
  - > Speech therapy; and
  - > Respiratory therapy.
- Psychiatric care services, including:
  - > Inpatient medical services for treatment of mental illness by a Physician or other professional provider for medical care visits (limited to one visit per day), individual psychotherapy, group psychotherapy, psychological testing, and family counseling; and
  - > Outpatient psychiatric care services when provided for treatment of mental illness by a Hospital, Physician, or other professional provider.
- Ambulance service providing transportation by means of a specifically designed and equipped vehicle used only for transporting Sick and Injured.
- Private duty nursing services of a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) when ordered by a Physician, including inpatient services and home services.
- Skilled Nursing Facility services when confined as an inpatient. However, no benefits are paid after the maximum level of recovery possible is reached, when confinement is intended solely to assist with activities of daily living, or for the treatment of alcoholism, drug addiction, or mental illness.

- Home health care services provided by a Hospital or Home Health Care Agency when prescribed by the attending Physician prior to discharge from the Hospital or other facility. The individual must be confined at home and home health care services must be rendered for treatment of the same Illness or Injury for which the individual was Confined, including:
  - > Professional services of an RN, LPN, or LVN;
  - > Physical Therapy;
  - > Medical and surgical supplies provided by the home health care provider;
  - > Prescribed drugs;
  - > Oxygen and its administration;
  - > Medical social service consultations;
  - > Health aide services to an individual receiving covered nursing or therapy services;
  - > Durable Medical Equipment; and
  - > Dialysis treatment for 30 days after discharge from the Hospital.

  No home health care benefits will be provided for dietitian services, homemaker services, maintenance therapy, purchase or rental of dialysis equipment, or food or home delivered meals.
- Durable Medical Equipment rental (not to exceed the total cost of purchase) or purchase when prescribed by a Physician or other professional provided as required for therapeutic use.
- Prosthetic appliances, including the purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies that replace all or part of an absent body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ.
- Orthotic devices, including rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part.
- Transportation, lodging, and meals (see *Benefit Maximums* below).

Certain limitations may apply to the above Covered Expenses. In addition, Prescription drugs are covered under the Plan's Prescription drug benefits. Contact the Fund Office for more detailed information or a copy of any insurance contracts governing these benefits.

## BENEFIT MAXIMUMS

You and each covered Dependent can receive Transplant Benefits up to the maximums specified on the *Summary Of Benefits* (in the back pocket of this booklet). These maximums are over and above the Plan's Comprehensive Medical Benefits Lifetime maximum. Specific benefit maximums are included in the Transplant Benefit Lifetime maximum per procedure.

- Transplant Benefit Lifetime Maximum: The Lifetime maximum benefit listed on the *Summary Of Benefits* (in the back pocket of this booklet) is applied per type of transplant. Benefits for subsequent retransplantations are combined with previous benefits paid for the initial transplant and any other retransplantations in determining whether the maximum benefit per Lifetime has been reached. Benefits for circulatory assist devices are combined with any benefits paid for a heart transplant in determining whether the maximum benefit per heart transplant per Lifetime has been reached. Benefits for hepatic assist devices are combined with any benefits paid for a liver transplant in determining whether the maximum benefit per liver transplant per Lifetime has been reached.

- Organ Procurement Maximum: All procurement expenses will be reimbursed up to the maximum listed on the *Summary Of Benefits* (in the back pocket of this booklet). With regard to the donation of:
  - > An organ, procurement expenses include surgical, storage, and transportation costs incurred and directly related to the donation of an organ to be used in a covered organ transplant procedure, including costs resulting from complications of the donor's surgery. If the organ is donated by a living donor, the maximum only includes costs resulting from complications of the donor's surgery that are incurred within 120 days from the date of the donor's surgery.
  - > Bone marrow and peripheral stem cells, procurement expenses include harvest and acquisition expenses for bone marrow and peripheral stem cell transplants.
- Recipient Transportation, Lodging, and Meals Maximum: All reasonable and necessary lodging and meal expenses incurred, up to the daily maximum will be reimbursed. The sum of all costs of transportation, lodging, and meals is subject to an overall maximum. The following transportation, lodging, and meal expenses will be reimbursed up to the maximums listed on the *Summary Of Benefits* (in the back pocket of this booklet) for each covered transplant procedure completed.
  - > If the recipient of the covered transplant procedure is an adult, costs of transportation to and from the site of the covered transplant procedure for the recipient and one other individual will be reimbursed.
  - > If the recipient of the covered transplant procedure is a minor, costs of transportation to and from the site of the covered transplant procedure for the recipient and two other individuals will be reimbursed.

## PROCEDURES SCHEDULED BUT NOT PERFORMED

If a covered transplant procedure is not performed as scheduled, due to the intended Eligible Person's medical condition or death, then benefits are provided for charges directly related to that scheduled transplant (except procurement expenses) that are incurred five days before the scheduled or attempted transplant procedure, including the date of the scheduled or attempted transplant procedure and the following day or the date of death, whichever is earlier. If the transplant would have made use of an organ from a living related donor, procurement expenses will be reimbursed if they occur within five days of the date of the scheduled transplant.

If a bone marrow or stem cell transplant infusion is not performed as scheduled after the high dose portion of the therapy has begun due to the intended Eligible Person's medical condition or death, then benefits are provided for procurement charges directly related to the scheduled transplant procedure that are incurred 30 days before the scheduled transplant procedure, extending to and including the scheduled date of the transplant procedure or extended to and including the date of death, whichever is earlier.

All expenses to be reimbursed are subject to the Transplant Benefit maximum benefits (see page 52). All expenses incurred as a result of one or more failed transplant(s) will be used in calculating the maximum benefits paid.

## EXTENDED TRANSPLANT BENEFITS

If your coverage under the Plan ends and you have already begun the process of having a transplant, coverage continues for the duration of the applicable benefit period or until your expenses reach the Lifetime maximum.

## PREEXISTING CONDITIONS

The Plan's Preexisting Condition provision applies to Transplant Benefits, see page 6. During the first 12 months of an eligible individual's coverage (the Preexisting Condition limitation period), no benefits will be paid for conditions that existed in the 12-month period immediately preceding coverage under the Plan.

A Preexisting Condition means either:

- A Physician's diagnosis indicating that a transplant is recommended; or
- A transplant has been approved and/or scheduled within the 12-month period immediately preceding coverage under the Plan.

However, if the eligible individual had health insurance coverage within the 63 days immediately before becoming covered under the Plan and such prior coverage included organ and/or bone marrow transplants, the individual will receive credit equal to his or her length of coverage for the type and scope of coverage under the prior coverage toward the Preexisting Condition limitation period. If coverage under this Plan is more comprehensive than the prior coverage, this credit will be limited to the type and scope of coverage under the prior coverage.

Eligible individuals that have been considered, recommended, approved, or scheduled for a transplant by a Physician at any time within the 12 months before becoming covered under this Plan, will not be eligible for this prior coverage credit, unless approved in writing. In addition, eligible individuals who are totally Disabled immediately before becoming covered under the Plan, will not be eligible for this prior coverage credit, unless approved in writing.

## TRANSPLANT BENEFIT EXCLUSIONS AND LIMITATIONS

You should be aware that some expenses are not covered under the Plan's Transplant Benefits. Except as specifically provided in the policy and in addition to any *General Plan Exclusions And Limitations* (see page 66), Transplant Benefits are not paid for the following expenses.

1. Care, services, or supplies:
    a. Care, services, or supplies not prescribed by or performed by or upon the direction of a Physician or professional/facility Provider.
    b. Care, services, or supplies rendered by a provider that is a member of the Participants' immediate family.
    c. Care, services, or supplies rendered by Hospitals, Physicians, or other providers that do not meet the Plan's definitions of such providers.
    d. Hospice care.

2. Charges:
    a. Charges a Participant would not legally have to pay if there were no insurance.
    b. Charges for personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment.
    c. Charges for telephone consultations, failure to keep a scheduled visit, or for completion of a claim form.
3. Cosmetic: Surgery and any related services intended solely to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies, or previous therapeutic process.
4. Custodial: Custodial Care, domiciliary care, or rest cures.
5. Experimental or Investigative: Treatment that is Experimental or Investigative in nature.
6. Medical Necessity: Services or supplies that are not Medically Necessary.
7. Other Coverage:
    a. Provided, or would be provided, by any governmental unit, such as Medicare.
    b. Received from a medical department maintained by or on behalf of an Employer, a mutual benefit association, labor union, trust, or similar person or group.
    c. Related to any Illness or bodily Injury that occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of any governmental unit. This applies whether or not the individual claims the benefits or compensation or recovers losses from the third party.
    d. To the extent payment has been made under Medicare or would have been made if applied for and claimed (i.e., multi-visceral transplants where one organ is payable by Medicare, such as kidney and heart transplant where the kidney transplant is payable by Medicare).
8. Rehabilitation:
    a. Treatment for alcoholism.
    b. Treatment for drug abuse.
9. Transplant:
    a. For a transplant procedure performed after the date coverage ends, including a transplant performed with a benefit period beginning after coverage ends but performed during a continuous Hospital stay that began before coverage ended.
    b. For a transplant procedure performed prior to becoming eligible or during an inpatient admission that began before being covered.
    c. For any Illness or Injury suffered after becoming eligible that is not a direct result of a transplant procedure or complication covered under the Plan.
    d. For any non-human organ transplant.
    e. For a bone marrow transplant in persons infected with any of the Human Immunodeficiency Viruses.
    f. For donor expenses other than those specifically listed as covered.
    g. For non-transplant related costs.
    h. For recurrence of the disease for which the transplant was performed.

# DENTAL BENEFITS

IN THIS SECTION >>


COVERED EXPENSES 56
- Diagnostic And Preventive Care 57
- Routine Procedures 57
- Orthodontic Services (Braces) 58

DENTAL BENEFIT EXCLUSIONS AND LIMITATIONS 58


The Fund provides coverage for dental care for Active Participants and their eligible Dependents. Coverage is provided to Retired Participants (and their eligible Dependents) who are enrolled and make self-payment contributions for this coverage.

## COVERED EXPENSES

There is no flat dollar amount paid for benefits. Instead, dental coverage is based on Usual, Customary and Reasonable Charges (UCR) as specified on the *Summary Of Benefits* (in the back pocket of this booklet). Dental Benefits are separated into three categories of services:

- Diagnostic and Preventive;
- Routine (Restorative, Endodontic, Periodontic, and Prosthetics); and
- Orthodontics (braces—for Dependent children only).

The Plan does limit certain expenses paid for Dental Benefits. The per person Calendar Year maximum for Restorative, Endodontic, Periodontic, and Prosthetic Procedures is listed on the *Summary Of Benefits* (in the back pocket of this booklet). This Calendar Year maximum does not apply to Diagnostic and Preventive Services or Orthodontic services. However, the Plan does have a separate Lifetime maximum for Orthodontic services (see the *Summary Of Benefits* in the back pocket of this booklet).

**COORDINATION OF BENEFITS**

ALL DENTAL BENEFITS ARE COORDINATED WITH BENEFITS UNDER OTHER DENTAL PLANS. SEE THE EXPLANATION ON PAGE 78.

**BENEFITS PAID WHERE A THIRD PARTY MAY BE LIABLE**

THE FUND MAY MAKE A CLAIM AGAINST A THIRD PARTY FOR DENTAL BENEFITS WHERE EXPENSES ARE PAID AS A RESULT OF AN ILLNESS, INJURY OR DEATH CAUSED BY ANOTHER PERSON. SEE PAGE 84 FOR A DETAILED EXPLANATION.

Where more than one Dental Procedure can be performed for a specific purpose, Dental Benefits are provided only for the least expensive satisfactory treatment. When the charge is higher than the Usual, Customary and Reasonable Charge, you will be informed through the Explanation of Benefits (EOB). You are responsible for paying the difference between the Plan's benefit and the amount charged. To protect yourself against having to pay excessive dental expenses, request that your Dentist submit a Pretreatment Estimate to the Fund Office.

### DIAGNOSTIC AND PREVENTIVE CARE

Diagnostic and Preventive care services and procedures include:

- Up to two routine oral examinations per Calendar Year, including bite-wing x-rays;
- Up to two cleanings (prophylaxis) each Calendar Year (these may be done by a Dental Hygienist);
- One full mouth x-rays every two Calendar Years; and
- One topical fluoride treatment per Calendar Year.

Diagnostic and Preventive care expenses are not subject to the Plan's Calendar Year dental maximum.

### ROUTINE PROCEDURES

The Plan covers routine dental expenses, including implants, Restorative, Endodontic, Periodontic, and Prosthodontic (the artificial replacement of missing teeth or a part of a tooth). Dental services and procedures covered under this category include:

- Palliative exams that are related to treatment;
- Restorative services, including restoration with amalgam, synthetic porcelain, and plastic materials. Restorations made with gold are included only if the teeth cannot be restored with the other materials listed previously;
- Endodontic services, including pulpal therapy and root canal filling;
- Periodontic services, including procedures for treating gums and the supporting structures of the teeth. Oral Surgery is not covered under the dental portion of the Plan; however, it may be covered under the Plan's medical benefits; and
- Prosthetic services, including bridges, partial and complete dentures, and services related to making existing dentures satisfactory. Replacement of existing dentures is made only if they are unsatisfactory. The replacement of dentures or other prosthetic appliances is allowable only once in a five-year period. Procedures to reline and rebase—not within six months of the initial placement and not more than once in any 36-month period for any covered person.

Dental care included in this category is subject to the Calendar Year maximum.

### ORTHODONTIC SERVICES (BRACES)

Your eligible Dependent children are covered if they need Orthodontic care. Benefits are paid as specified on the *Summary Of Benefits* (in the back pocket of this booklet) based on the Usual, Customary and Reasonable Charges incurred during an entire period of Orthodontic treatment, provided your Dependent is eligible when the treatment begins and during the entire course of treatment.

Benefits payable for Orthodontic treatment are subject to the Lifetime maximum benefit, which means the aggregate amount payable for all Orthodontic expenses incurred during each Eligible Dependent's Lifetime.

Eligible dental expenses under this provision are expenses incurred as the result of the initial and subsequent installation of Orthodontic appliances, including all Orthodontic treatment rendered by an orthodontist preceding and subsequent to the installation.

Orthodontic benefits are payable on an itemized basis. When the orthodontist submits itemized statements during a period of Orthodontic treatment, benefits are paid as expenses are incurred and submitted for payment.

## DENTAL BENEFIT EXCLUSIONS AND LIMITATIONS

You should be aware that some items of dental care are not covered by the Plan. In addition to any *General Plan Exclusions And Limitations* (see page 66), Dental Benefits are not paid for the following expenses.

1. Prosthetic replacement more than once in a five-year period, unless Medically Necessary.
2. Replacement of a lost or stolen appliance or of duplicate appliances.
3. Services:
   a. Equipment sterilization.
   b. Oral Surgery and Temporomandibular Joint Disorder treatment (both are covered under Comprehensive Medical Benefits).
   c. Preventive control programs, including oral hygiene instruction, plaque control, hydrotherapy, or dietary planning.
   d. Rebase or reline of dentures within six months of initial placement.

**WHEN MORE THAN ONE DENTAL PROCEDURE CAN BE PERFORMED FOR A SPECIFIC PURPOSE, DENTAL BENEFITS ARE PROVIDED ONLY FOR THE LEAST EXPENSIVE SATISFACTORY TREATMENT.**

**KEEP IN MIND THAT PAYMENT FOR ORTHODONTIC TREATMENT IS SUBJECT TO A LIFETIME MAXIMUM.**

4. Temporary procedures.
5. Orthodontic treatment for the Participant or spouse.
6. Treatment, care, services, or supplies incurred before you or your eligible Dependents were covered under this Plan, including dental treatment furnished for prosthetic services or devices (including crowns and bridges) started before the Eligible Person's effective date (such services are considered started when impressions and fittings have been made)

# VISION BENEFITS

IN THIS SECTION >>


COVERED EXPENSES 60
VISION BENEFIT EXCLUSIONS AND LIMITATIONS 61


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. Coverage is also provided to eligible Retired Participants and their Dependents who have enrolled and made self-payment contributions for this coverage.

The plan pays 100% of vision expenses up to the per person annual maximum listed on the *Summary Of Benefits* (in the back pocket of this booklet). 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.

## COVERED EXPENSES

Vision Benefits covered under the Plan may include:

- A complete eye examination;
- Eyeglass lenses and frames including single vision, bifocal, trifocal, and lenticular lenses); and
- Contact lenses.

Services must be provided by and supplies received from a legally qualified Optician, Optometrist, or Ophthalmologist, acting within the usual scope of his or her practice, to be eligible expenses under the Plan.

**COORDINATION OF BENEFITS**

**ALL VISION BENEFITS ARE COORDINATED WITH BENEFITS UNDER OTHER HEALTH PLANS. SEE THE EXPLANATION ON PAGE 78.**

## VISION BENEFIT EXCLUSIONS AND LIMITATIONS

You should be aware that some items of vision care are not covered by the Plan. In addition to any *General Plan Exclusions And Limitations* (see page 66), 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. Services performed or supplies furnished by other than an Optician, Optometrist, or Ophthalmologist.
   e. Supplemental services not covered in basic care.
2. Supplies, including:
   a. Aniseikonic lenses (for binocular vision).
   b. Non-prescription lenses.
   c. Non-prescription sunglasses.
   d. Subnormal vision aids.
3. Laser surgery, including PRK, LASIK, and similar surgeries for the correction of vision.
4. Treatment, care, services, or supplies incurred after eligibility for coverage ceases, except as specifically noted elsewhere in this booklet, including vision services rendered after coverage ends, except that lenses and frames ordered before coverage ended will be covered if they are delivered within 31 days.

# LOSS OF TIME (SHORT-TERM DISABILITY) BENEFITS

IN THIS SECTION >>

LOSS OF TIME BENEFIT EXCLUSIONS AND LIMITATIONS 63

If you are an Active Participant unable to work because of a non-job related Illness or because of an Injury caused by an Accident off the job, and you are under the regular care of a qualified Physician, you are eligible to receive Loss of Time Benefits (short-term Disability benefits).

If you are under the regular care of a qualified Physician, benefits begin on the:

- First day you are off work due to an Accident off the job; or
- Eighth day you are off of work due to a non-job related Illness.

Loss of Time Benefits are paid weekly, at the rate listed on the *Summary Of Benefits* (in the back pocket of this booklet). Benefits may run for a maximum of 26 weeks for any one Period of Disability.

Successive periods of Disability due to the same or related causes not separated by a return to Active employment are considered one Period of Disability.

To be eligible for coverage as an active employee following a Period of Disability, you must have a release from your Physician to return to work and you must work at least 40 hours. If you return to work for at least 40 hours after being released by your Physician, and have to leave work again because of a Disability, a new Period of Disability begins. You must return to work and have at least 40 hours of contributions made on your behalf after one Period of Disability to qualify for a second or succeeding Period of Disability for Loss of Time Benefits.

**LOSS OF TIME BENEFITS ARE FOR ACTIVE PARTICIPANTS ONLY. HOWEVER, LOSS OF TIME BENEFITS ARE NOT AVAILABLE TO SALARIED ALUMNI OR NON-BARGAINING UNIT PARTICIPANTS.**

You do not have to be confined to your home to collect benefits, but you must be under the care of a Physician. For a Disability lasting less than one full week, benefits are paid based on the ratio of the number of days of Disability divided by the number of days in the week. In any event, no Disability is considered as beginning before the first visit to a Physician.

While you are receiving Loss of Time Benefits, you continue to receive credit for hours toward eligibility. If you are receiving Workers' Compensation benefits, you will receive credit for hours toward eligibility if you notify the Fund Office, in writing. In either case, you will receive credit for up to 25 hours of contributions each week, not to exceed 100 hours per month, to a maximum of:

- 24 months if you are receiving Workers' Compensation benefits; or
- 26 weeks if you are receiving Loss of Time Benefits.

Loss of Time Benefits are subject to federal income tax, which you can elect to have withheld. Social Security taxes are also withheld. The last Employer for whom you worked immediately prior to your Disability will send you a W-2 Form after the end of the year to report this taxable income.

## LOSS OF TIME BENEFIT EXCLUSIONS AND LIMITATIONS

In addition to any *General Plan Exclusions And Limitations* that apply (see page 66), Loss of Time Benefits are not paid for any period of time for which you are:

1. Being treated for mental health, eating disorders, or substance (alcohol or drug) abuse on an outpatient basis.
2. Receiving benefits under Workers' Compensation or occupational disease laws.
3. Receiving wages or salary.

In addition, the Preexisting Condition provision described on page 6 also applies to Loss of Time Benefits.

# DEATH AND DISMEMBERMENT BENEFITS

IN THIS SECTION >>


DEATH BENEFIT 64
ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT 64
AD&D Benefit Exclusions And Limitations 65
BENEFICIARY 65


All Active and Retired Participants who have satisfied the eligibility requirements are covered by the Death Benefit and Accidental Death and Dismemberment Benefit programs. Dependents and surviving spouses are not eligible for coverage.

## DEATH BENEFIT

In the event of your death while eligible for benefits from the Fund, your designated beneficiary will receive the Death Benefit. If your death is caused by an Accident caused as a result of any employment or work for profit (and occurs within 90 days of the Accident), the Plan will pay the Accidental Death and Dismemberment Benefit. This benefit is paid in addition to the Death Benefit.

The amount of the Death Benefit is listed on the *Summary Of Benefits* (in the back pocket of this booklet).

## ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT

The AD&D Benefit is paid in the event of your death or Injury due to a non-work related Accident, provided the death or Injury results within 90 days of such Accident. The full amount of the AD&D Benefit is listed on the *Summary Of Benefits* (in the back pocket of this booklet) and is paid as follows:

| For Loss Of: | Benefit |
|---|---|
| Life | Full Amount |
| Both Hands, Both Feet, Sight In Both Eyes, Or Any Combination (for example, one hand and one foot) | Full Amount |
| One Hand, One Foot, Or Sight In One Eye | Half Of Full Amount |

**DEATH AND AD&D BENEFITS ARE FOR ACTIVE AND RETIRED PARTICIPANTS ONLY; DEPENDENTS AND SURVIVING SPOUSES ARE NOT COVERED.**

No more than the full amount of the AD&D Benefit will be paid for one Accident.

In the event of your death, the benefit is paid to your beneficiary. In the event of an accidental injury for which you are eligible for benefits the benefit is paid to you.

### AD&D BENEFIT EXCLUSIONS AND LIMITATIONS

In addition to any *General Plan Exclusions And Limitations* that apply (see page 66), AD&D Benefits are not paid for death caused by:

1. Accidents while operating an aircraft.
2. Accidents while riding in an aircraft other than as a passenger in a commercial aircraft on a regularly scheduled passenger flight.
3. Self-inflicted Injury or suicide.

## BENEFICIARY

The Plan pays the Death Benefit to the beneficiary you designate and who is on record with the Fund Office. You may change your beneficiary at any time. To change beneficiaries, contact the Fund Office. The Fund Office will give 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 is paid to your surviving:

- Spouse; or if none,
- Children in equal shares; or if none,
- Parents in equal shares; or if none,
- Brothers and sisters in equal shares; or if none,
- Estate.

# GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The Plan provides coverage for many medical, Prescription drug, transplant, dental, vision, disability, and death benefits. In addition to any specific exclusions and limitations listed through out this booklet, Plan benefits are not paid for the following.

1. Charges:
   a. For completion of claim forms or failure to keep any appointment.
   b. Above the Usual, Customary and Reasonable Charges of the Plan.
   c. Related to interest on expenses or sales tax.
2. Cosmetic: Treatment, surgery, and any related services intended solely for cosmetic purposes or to improve appearance, except when necessitated by mastectomy or congenital malformations but not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies, or previous therapeutic process, including, but not limited to:
   a. Cosmetic reconstruction of the nose;
   b. Electrolysis;
   c. Keloids;
   d. Removal of wrinkles or excess skin;
   e. Revision of previous elective procedures;
   f. Treatment of male pattern baldness; and
   g. Wigs.

**CUSTODIAL CARE, WHICH IS NOT COVERED UNDER THE PLAN, INCLUDES EXPENSES INCURRED FOR ACCOMMODATIONS (INCLUDING ROOM AND BOARD AND OTHER INSTITUTIONAL SERVICES) AND NURSING SERVICES, DUE TO AGE OR A MENTAL OR PHYSICAL CONDITION, PRIMARILY TO ASSIST A PATIENT IN DAILY LIVING ACTIVITIES.**

3. Custodial:

   a. Any charges for Custodial Care, domiciliary care, or rest cures. The fact that a Participant is also receiving medical services that are merely maintenance care that cannot reasonably be expected to substantially improve a medical condition does not prevent this limitation from applying.

   b. Medical supplies and Durable Medical Equipment used only for a Participant's comfort, personal hygiene, or convenience including, but not limited to air conditioners, air cleaners, humidifiers, dehumidifiers, purifiers, physical fitness equipment, Physician's equipment, disposable supplies other than colostomy supplies, self-help devices not medical in nature, and similar equipment.

4. Experimental/Investigative: Treatment, care, services, or supplies (including Prescription medications) of any kind that is Experimental or Investigative in nature or not generally accepted practice by the medical (or applicable) community.

5. Governmental: Any treatment, care, services, or supplies furnished by or payable under any plan or law through any municipal, state, or federal government or any political subdivision (this applies whether or not the Eligible Person claims the benefits or compensation and whether or not the Eligible Person recovers losses from a third party), except for:

   a. The Veterans Administration, when services are provided to a veteran for a Disability that is not service connected;

   b. A military Hospital or facility, when services are provided to a retiree (or Dependent of a retiree) from the armed services; or

   c. A group health plan established by a government for its own civilian employees and their Dependents.

6. Other Coverage: Any treatment, care, services, or supplies for which you or your eligible Dependents have received or are entitled to receive benefits under a Workers' Compensation, occupational disease law, employers' liability law, or similar law or that arise out of or in the course of any occupation or employment (regardless of whether or not the Eligible Person is paid in cash). This applies whether or not the Eligible Person claims the benefits or compensation, whether or not the Eligible Person recovers losses from a third party, and whether or not the Eligible Person is not eligible due to non-payment of premiums by an employer. However, if you or your eligible Dependents have been denied Workers' Compensation, occupational disease benefits, employer liability laws, or government benefits, and have filed an appeal with the appropriate state agency, you and your attorney must execute an agreement stating and agreeing to repay and reimburse the Fund for all benefits paid by the Fund on behalf of the Eligible Person for said services and treatments out of **any** Recovery proceeds, whether by settlement or otherwise.

7. Preexisting Condition: Preexisting Conditions to the extent described in this booklet.

8. Pre-Eligibility: Treatment, care, services, or supplies incurred before you or your eligible Dependents were covered under this Plan, including:

   a. Dental treatment furnished for prosthetic services or devices (including crowns and bridges) started before the Eligible Person's effective date (such services are considered started when impressions and fittings have been made); and

   b. Transplant procedures performed prior to an Eligible Person's effective date or during an inpatient admission that began before the Eligible Person's effective date.

9. Post-Eligibility: Treatment, care, services, or supplies incurred after eligibility for coverage ceases, except as specifically noted elsewhere in this booklet, including:

   a. Vision services rendered after coverage ends, except that lenses and frames ordered before coverage ended will be covered if they are delivered within 31 days; and

   b. Transplant procedures performed with a transplant benefit period beginning on the termination date of an Eligible Person's coverage but performed during a continuous Hospital stay, which began before that termination date;

10. Treatment, Care, Services, or Supplies:

   a. For which no charge is made or incurred, or for which you would not be required to pay if you did not have coverage (unless otherwise required by applicable federal law).

   b. Not Medically Necessary for the treatment of an Illness or Injury, including those not prescribed by or performed by or upon the direction of a Physician or other professional/facility provider.

c. Other than those specifically listed as Covered Expenses.

d. Provided through a medical department, clinic, or similar facility provided or maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.

e. Rendered by a person who ordinarily resides in your home or who is a member of the Eligible Person's immediate family.

f. Required while incarcerated in a federal, state, or local penal institution, or required while in custody of federal, state or local law enforcement authorities, including under the Huber law.

g. Resulting from any Injury sustained or Illness contracted while on duty with any military, naval, or air force of any country or international organization or the result of an act of declared or undeclared war (including resistance to armed aggression).

IN THIS SECTION >>


FILING A CLAIM – GENERAL PROCEDURES 70
Itemized Bills 71
Provide All Necessary Information 71
FILING SPECIFIC BENEFIT CLAIMS 72
Health Care Claims 72
Coverage Under More Than One Plan 72
Assignment Of Benefits 72
Pretreatment Estimates 72
Prescription Drug Claims 72
Types Of Health Care Claims 73
Loss Of Time Claims 73
Supplementary Report For Loss Of Time Benefits 73
Death And Dismemberment Claims 73
CLAIM DECISIONS AND PAYMENT OF CLAIMS 74
Health Care Claims 74
Loss Of Time Benefit Claims 74
Death And Dismemberment Benefit Claims 75
IF A CLAIM IS DENIED 75
Information Requirements 75
APPEALING A DENIED CLAIM 75
APPEAL DECISIONS 76
Appeal Timeframes 76
Medical Judgements 77
Information Requirements 77
COORDINATION OF BENEFITS 78
Order Of Payment 78
COORDINATION OF BENEFITS WITH MEDICARE 79
How The Plan Coordinates Benefits With Medicare 80
INFORMATION GATHERING 81
PRIVACY POLICY 81
Use And Disclosure of Protected Health Information 81
Health Care Operations 82
Additional Privacy Information 83
BENEFITS PAID WHERE A THIRD PARTY MAY BE LIABLE 84
Agreement To Reimburse Plan For Other Payments 84
Plan's Right Of Subrogation 85
Compensated Injuries 86
Definitions 86
RIGHT OF RECOVERY 87


# CLAIMS INFORMATION

This section describes how to file a claim, when claims are paid, and what to do if a claim is denied. If a claim is denied, in whole or in part, there is a process you can follow to have your claim reviewed by the Trustees.

## FILING A CLAIM – GENERAL PROCEDURES

If you have any questions about filing a claim, call the Fund Office at (262) 549-9190 or toll-free at (800) 242-7018.

In addition, you may e-mail the Fund Office. Visit the Web site at www.iuoe139.org for more information.

To assist the Fund Office in processing claims as quickly as possible, please follow these general steps.

Step 1: Obtain the appropriate claim form from the Fund Office (or you may use a standard form used by most providers).

Step 2: Complete the form by filling in all information requested (see the following information for specific information required for each type of claim). Be sure to complete and submit a separate form for each family member.

Step 3: When necessary, have your provider complete the appropriate portion of the claim form, including the diagnosis if applicable.

Step 4: Attach all itemized bills for the individual to your claim form; make sure the bills include the information listed for the specific type of claim.

Step 5: Forward the completed form and all related bills to:

Operating Engineers Local 139
Health Benefit Fund
P.O. Box 160
Pewaukee, Wisconsin 53072-0160

**MOST PROVIDERS WILL FILE CLAIMS FOR YOU. IF YOUR PROVIDER DOES NOT, FOLLOW THE STEPS LISTED IN THIS SECTION.**

**REFER TO YOUR ELIGIBILITY ID CARD FOR INFORMATION RELATING TO WHERE TO FILE CLAIMS. GENERALLY, WHEN YOU USE A PREFERRED PROVIDER, THE PROVIDER WILL FILE CLAIMS FOR YOU.**

**IF YOU OR AN ELIGIBLE DEPENDENT HAS COVERAGE UNDER MORE THAN ONE HEALTH CARE PLAN, BENEFITS ARE COORDINATED (SEE PAGE 78).**

You should file a written claim with the Fund Office within 90 days of incurring covered charges. Late claims are difficult for the Fund Office to process. Therefore, if you do not file your claim within 18 months of the date of the service, your claim may not be accepted and may be denied.

### ITEMIZED BILLS

An itemized bill should show:

- Your name and Social Security number;
- The patient's name;
- The Physician's name;
- The Physician's tax identification number;
- The dates of treatment or purchase;
- The type of services (Physician's office visit, Hospital, lab tests, etc.);
- The charge made for each service;
- The condition for which the charge was incurred (the diagnosis); and
- If due to an Injury, indicate how, when, and where the Injury occurred.

If your bills clearly show all the above information, it may not be necessary to submit the Fund's claim form.

### PROVIDE ALL NECESSARY INFORMATION

You can avoid unnecessary delays in processing your claims by providing all the necessary information. 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 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; and
- Verification of a Dependent's student status, if applicable.

If you are submitting claims yourself, be sure to double check that you have included all the necessary information before you send them in.

Information most often omitted by Physicians in completing their portion of claim forms includes:

- Diagnosis of the condition for which the patient received treatment;
- The Physician's tax identification number; and
- Correct itemization for charges.

**Remember, all claims, whether submitted by you or your provider, should be mailed directly to the address listed on your Eligibility ID card.**

**MOST LIKELY, YOU WILL NOT KNOW IF YOUR PHYSICIAN OMITS INFORMATION; HOWEVER, A REMINDER TO THE RECEPTIONIST OR NURSE IN THE PHYSICIAN'S OFFICE THAT SUCH INFORMATION IS IMPORTANT MAY HELP.**

**CONTACT THE FUND OFFICE FOR INFORMATION ABOUT FILING TRANSPLANT BENEFIT CLAIMS.**

**WHEN YOU OR A DEPENDENT ARE COVERED UNDER MEDICARE, WITH MEDICARE AS THE PRIMARY PAYOR, YOU MUST SUBMIT A COPY OF MEDICARE'S EOB WITH YOUR CLAIM.**

# FILING SPECIFIC BENEFIT CLAIMS

The following sections provide information for filing specific benefit claims.

### HEALTH CARE CLAIMS

Many health care providers will submit claims for you. Health care claims include medical, transplant, Prescription drug, dental, vision, and hearing care benefits. Be sure to show your Eligibility ID card so your provider knows where to submit your claim. If your provider does not submit your claim for you, it is then your responsibility to do so.

You must submit your mental health and substance abuse claims and appeals directly to HMC. For more detailed information, contact the Fund Office for a free copy of HMC's *Summary of Benefits* booklet.

### Coverage Under More Than One Plan

If you or an Eligible Dependent has coverage under two or more health plans, be sure to include the name of the other health plan(s) on your claim form. In addition, if you are also covered by Medicare and/or another plan, attach a copy of the itemized bill relating to the health service provided and a copy of any Explanation of Benefits (EOB). Both the bill and EOB must be submitted.

If Medicare is your or your Dependents' primary payor, 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 Office so benefits can be coordinated with payment from Medicare (as described on page 79).

**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 your claim will be processed.**

### Assignment Of Benefits

If you want the Fund to pay your provider directly, sign the "Assignment of Benefits" portion of the form. Then, the Fund makes direct payment to the provider and sends you an EOB so you know what has been paid.

### Pretreatment Estimates

If you wish to know, in advance, if the charges of your provider are considered Usual, Customary and Reasonable Charges by the Fund or if a series of dental treatments is expected to cost more than $100, 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.

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 Charges. If the provider charges an amount over the Usual, Customary and Reasonable Charge, 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.

### Prescription Drug Claims

If the claim is for Prescription drug benefits, you must provide a pharmacy receipt and include the following information:

- Your name and Social Security number;
- The patient's name;
- The Physician's name;
- Prescription number;
- Name of the medicine; and
- Cost of Prescription.

**UNDER THE PLAN, ONLY EMERGENCY ADMISSIONS FOR MENTAL HEALTH AND/OR SUBSTANCE ABUSE TREATMENT ARE CONSIDERED URGENT CARE CLAIMS.**

### Types Of Health Care Claims

There are four basic types of health care claims:

- **Urgent Care.** An urgent care claim is a claim for medical care or treatment that:
  - > Would seriously jeopardize your life, health, or ability to regain maximum function if normal pre-service standards were applied; or
  - > Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.
- **Pre-Service.** A pre-service claim is a claim for treatment where the Plan requires that you obtain preauthorization (such as mental health treatment). The Plan will not deny benefits for these procedures or services if:
  - > It is not possible for you to obtain preauthorization; or
  - > The preauthorization process would jeopardize your life or health.
- **Post-Service.** A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services in your claim.
- **Concurrent Care.** A concurrent care claim is a claim that is reconsidered after it is initially approved (such as recertification of the number of days of a Hospital stay) and the reconsideration results in:
  - > Reduced benefits; or
  - > A termination of benefits.

While other claims have certain deadlines through out the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a concurrent claim. However, the Plan Administrator will notify you as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment.

## LOSS OF TIME CLAIMS

Request a claim form from the Fund Office and fill out items 1 through 6.

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.

When the form is completed, return it to the Fund Office.

### Supplementary Report For Loss Of Time Benefits

Loss of Time Benefits are paid based on your Physician's estimate of when you can return to work. The Fund Office may require, at any time, that your Physician complete a "Supplementary Report For Loss of Time Benefits" if there is any question regarding your Disability or if you are unable to return to work after the initial estimated return date that your Physician indicated.

## DEATH AND DISMEMBERMENT CLAIMS

Call or write the Fund Office and explain the type of claim you are filing. The Fund Office will send you the proper claim form.

Fill out the claim form and send it back to the Fund Office. For death claims, a certified copy of the death certificate will also need to be included.

**LEGAL ACTIONS**

**NO ATTEMPT TO RECOVER FROM THE FUND THROUGH LEGAL ACTION MAY BE MADE UNTIL 60 DAYS AFTER A COMPLETE CLAIM HAS BEEN FILED AND YOU HAVE FOLLOWED THE CLAIM APPEAL PROCEDURES (SEE PAGE 75).**

## CLAIM DECISIONS AND PAYMENT OF CLAIMS

When you submit a claim for benefits to the Fund Office, the Fund Office will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. All claims are processed promptly by the Fund Office, when complete claim information is received. For any loss for which recurrent payments are provided, benefit amounts are paid as they accrue, but not less often than monthly (or not less often than quarterly for Orthodontic benefits).

The Fund reserves the right to have the patient examined, at its own expense, as often as is reasonably necessary while a claim is pending to determine the proper benefit. The Fund may also have an autopsy performed, unless forbidden by law.

If payment of a claim is made to you on behalf of one of your covered Dependents (for example, if your ex-spouse or Dependent child submit a claim and payment is made to you), you are responsible for payment to the provider on behalf of that individual. Once the Fund makes payment on a claim, no further payment will be made.

### HEALTH CARE CLAIMS

Generally, once all required information is provided, health care benefits will be paid within 30 days after the claim is received (or as otherwise described below). The Plan will notify you of its initial decision within certain timeframes. If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, the Plan will give you written notice of its decision about your claim.

The deadlines differ for the different types of claims as shown in the following information:

- **Urgent Care Claims.** An initial determination will be made within 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. The notice will state the special circumstances and the date the Plan expects to make a decision. You will then have up to 48 hours to respond. The initial 72-hour deadline is suspended for up to 48 hours or until the information is received, if sooner.
- **Pre-Service and Post-Service Claims.** An initial determination will be made within 15 calendar days from receipt of your pre-service claim and within 30 calendar days from receipt of your post-service claim. If additional time is necessary, up to 15 additional calendar days, due to matters beyond the control of the Plan, you will be informed of the extension within this initial deadline. In addition, if additional information is needed to process your claim, you will be notified within 15 days of receipt of your claim and you then have up to 45 days to provide the requested information. The notice will state the special circumstances and the date the Plan expects to make a decision. After 45 days or, if sooner, after the information is received, the Plan will make a determination within 15 days.

Generally, when Preferred Providers submit the claims, payment is made directly to the provider. Preferred Providers handle all the paperwork for you. However, if you submit the claim, payments are generally made directly to you, unless you assign benefits to the Provider.

### LOSS OF TIME BENEFIT CLAIMS

Generally, you will receive written notice of a decision on your initial claim within 45 days of receipt of your claim. If additional time is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within this time. The Plan may extend this 45-day period up to an additional 60 days maximum. However, if a determination is not made within the first 75 days, you will be notified that an additional 30 days is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision.

In some instances the Plan may require additional information to process and make a determination on your claim. If such information is required, the Plan will notify you within 45 days of receiving your request. You then have up to 45 days in which to submit the additional information. If you do not provide the information within this time, then your claim may be denied.

**IN MOST CASES, DISAGREEMENTS ABOUT BENEFIT ELIGIBILITY OR AMOUNTS CAN BE HANDLED INFORMALLY BY CALLING THE FUND OFFICE. IF A DISAGREEMENT IS NOT RESOLVED, THERE IS A FORMAL PROCEDURE YOU CAN FOLLOW TO HAVE YOUR CLAIM RECONSIDERED.**

### DEATH AND DISMEMBERMENT BENEFIT CLAIMS

Generally you will receive written notice on a decision on your claim within 90 days after the Plan receives your claim. If circumstances require an extension of time for processing your claim, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. The extension will not be for more than 90 days from the end of the initial 90-day period.

## IF A CLAIM IS DENIED

If your claim is denied (in whole or in part), the Plan will:

- Provide you with certain information about your claim; and
- Notify you of its denial of your claim within certain timeframes as previously described.

### INFORMATION REQUIREMENTS

When the Plan notifies you of its initial denial on your claim, it will provide:

- The specific reason or reasons for the decision;
- Reference to the Plan provisions on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed; and
- A copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim.

In addition, for *health care* and *Loss of Time Benefit* claims the notice will include:

- A copy of any internal rule, guideline, protocol, or similar criteria that was relied on, or a statement that a copy is available to you at no cost upon request; and
- A copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request, if your claim is denied due to Medical Necessity, Experimental treatment, or similar exclusion or limit.

If your appeal is due to the denial of an urgent care claim, the notice will also include a description of the expedited review process.

## APPEALING A DENIED CLAIM

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal to the Board of Trustees at the Fund Office as soon as possible. For urgent care claims, your appeal may be made orally. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within:

- 180 days from the date of a decision for *health care* or *Loss of Time Benefit* claims; or
- 60 days from the date of a decision for *death* or *dismemberment* claims.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative. A health care professional that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

**ALL MENTAL HEALTH AND/OR SUBSTANCE ABUSE APPEALS MUST BE SENT TO HMC. FOR MORE INFORMATION ON APPEALING A DENIED CLAIM FOR MENTAL HEALTH AND/OR SUBSTANCE ABUSE, CONTACT THE FUND OFFICE FOR A FREE COPY OF HMC'S *SUMMARY OF BENEFITS* BOOKLET.**

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

- Submit additional materials, including comments, statements, or documents; and
- Request to review all relevant information (free of charge).

In addition, if your claim is for *health care* or *Loss of Time Benefits* and is denied based on:

- An internal rule, guideline, protocol, or other similar criteria, you have the right to request a free copy of such information; and
- A Medical Necessity, Experimental treatment, or similar exclusion or limit, you have the right to request a free copy of an explanation of the scientific or clinical judgment used for the determination.

You may request an opportunity to appear before the Board of Trustees (or an authorized committee of the Board) in person or by representative. If you don't request to appear before the Trustees, this will be considered a waiver of your right to do so and the Trustees will proceed to consider your appeal based on the written information submitted.

If you do request a hearing, you will be notified in writing of the date, time, and place of the hearing. At the hearing, you or your authorized representative is entitled to appear. You will have the right to present any additional information not previously submitted. If you request a hearing and do not appear at the hearing (without requesting a continuance), the Trustees will proceed to consider your appeal based on the written information submitted.

Make your written request for a claim appeal and submit any written comments to:

Board of Trustees
Operating Engineers Local 139 Health Benefit Fund
Office of the Administrative Manager
N27 W23233 Roundy Drive
P.O. Box 160
Pewaukee, Wisconsin 53072-0160

## APPEAL DECISIONS

If you file your appeal on time and follow any applicable required procedures, a new, full, and independent review of your claim will be made and the decision will not be deferred to the initial benefit decision. An appropriate fiduciary of the Plan will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The Plan will notify you, in writing, of the decision on any appeal within five calendar days. However, oral notice of a determination on your urgent care claims may be provided to you sooner.

### APPEAL TIMEFRAMES

The Plan's determination of its decision will be made within certain timeframes. The deadlines differ for the different types of claims as shown in the following information:

- **Health Care Claims:**
  - > *Urgent Care Claims.* A determination will be made within 72 hours from receipt of your appeal.
  - > *Pre-Service Claims*. A determination will be made within 30 calendar days from receipt of your appeal. If the appeal process has two levels, the determination will be made within 15 calendar days from receipt of your appeal for each level.
  - > *Post-Service Claims.* A determination will be made by the Trustees at their next regularly scheduled meeting (at least quarterly) that follows the receipt of the request for review. However, if the request is filed within 30 days of the date of the meeting, the determination may be made no later than the date of the second meeting following the receipt of the request for review. If special circumstances (such as the need to hold a hearing) require, the appeal decision can be made at the third meeting following the appeal request. However, the Plan will notify you of this extension prior to the extension time.
  - > *Concurrent Care Claims*. A determination will be made before termination of your benefit.

- **Loss of Time Benefits.** A determination will be made within 45 calendar days from receipt of your appeal. If special circumstances require an extension of time (up to 45 days), a decision will be made within 90 days after the date the Plan receives your request for review. However, the Plan may:
  - > Make its decision at the next quarterly meeting of the Board of Trustees; or
  - > If your appeal is received within 30 days of the meeting, make the decision at the following quarterly meeting.
- **Death or Dismemberment Benefits.** A determination will be made within 60 calendar days from receipt of your appeal. If special circumstances require an extension of time (up to 60 days), a decision will be made within 120 days after the date the Plan receives your request for review. However, the Plan may:
  - > Make its decision at the next quarterly meeting of the Board of Trustees; or
  - > If your appeal is received within 30 days of the meeting, make the decision at the following quarterly meeting.

If circumstances require an extension of time for deciding your appeal, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision.

### MEDICAL JUDGEMENTS

If your claim is denied on the basis of a medical judgment, the Plan will consult with a health care professional whom:

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and
- Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

You have the right to be advised of the identity of any medical experts consulted in making a determination of your appeal.

### INFORMATION REQUIREMENTS

When the Plan notifies you of its determination on your appeal, it will provide:

- The specific reason or reasons for the decision, including reference to the Plan provisions on which the decision was based;
- A statement notifying you that you have the right to request a free copy of all documents, records, and relevant information;
- Information relating to any additional voluntary appeal procedures offered by the Plan; and
- A statement that you may bring a civil action suit under ERISA.

In addition, for *health care* and *Loss of Time Benefit* claims the notice will include:

- A copy of any internal rule, guideline, protocol, or similar criteria that was relied on, or a statement that a copy is available to you at no cost upon request; and
- A copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request, if your claim is denied due to Medical Necessity, Experimental treatment, or similar exclusion or limit.

Under the documents creating the Benefit Fund (and the terms of the Plan), the Trustees have sole authority to make final determinations regarding any application for benefits, the interpretation of the Plan, and any administrative rules adopted by the Trustees. Benefits under this Plan will be paid only if and when the Board of Trustees, or persons to whom such decision making authority has been delegated by the Trustees, in their sole discretion, decides the Participant or beneficiary is entitled to benefits under the terms of the Plan. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan.

You must follow the Plan's claims and appeals procedures completely before you bring an action in court under the Employee Retirement Income Security Act of 1974 (ERISA) to obtain your benefits. You or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the review procedures

described in this section. You may, at your own expense, have legal representation at any stage of the review process. If a provision of the Trust Agreement or the Plan, or any amendment to the Trust Agreement or the Plan, is determined to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions or the Trust Agreement or Plan.

## COORDINATION OF BENEFITS

Your and your Dependents' benefits are coordinated with other group health plans or prepaid group health care plans. When the benefits from all plans are added together, you will receive no more than 100% of the expenses incurred.

In no event will this Plan's payment be more than what would have been paid if there were no other plan involved. Benefits payable under another plan include any benefits that would have been payable, even though you may not actually have filed a claim.

### ORDER OF PAYMENT

The Plan's Coordination of Benefits provisions determine which plan is primary (pays benefits first) and which plan is secondary.

The Plan pays regular benefits when this Plan is the primary plan. When This Plan is the secondary plan, benefits the Plan pays will be no more than the total percentage of costs that this Plan would have paid had it been the primary plan. Remember that the Plan will not pay an amount that is greater than, when added to other amounts paid or payable, the actual expenses incurred.

In general, here's how benefits are coordinated:

- If another plan covering an Eligible Person does not have a Coordination of Benefits provision, then that plan is primary.
- If the Coordination of Benefits provision of another plan specifies that this Plan be primary, then benefits payable by the other plan are ignored by this Plan when benefits are calculated.
- If a plan covers an individual as an employee, then that plan is primary over a plan that covers an individual as a dependent or laid-off or retired employee (or as a dependent of a laid-off or retired employee).

In the event that the individual covered under more than one plan is a Dependent child, the following rules determine which plan is primary:

- If the parents are not divorced or separated:
  - > The plan of the parent whose birthday is earlier in the year (excluding the year of birth) is primary;

    **Birthday Rule Example**

    Jeff's mother's birthday is March 3rd and his father's birthday is August 20th.His mother's plan is primary because her birthday is earlier than his father's. This is called the "birthday rule."

  - > If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period of time is primary;
  - > If a plan does not follow the birthday rule, then the rules of that plan determine the order of payment; or
  - > If none of the above apply, the plan covering the individual the longest is primary.
- If the parents are divorced or separated:
  - > If there is a court decree that establishes financial responsibility for health care expenses, the plan covering the Dependent child of the parent who has financial responsibility is primary; or
  - > If there is no court decree or a decree that does not establish financial responsibility for health care expense, the plan of the:
    - > Parent with custody pays first; then
    - > Spouse of the parent with custody (if applicable) pays next; then
    - > Parent without custody pays next; then
    - > Spouse of the parent without custody pays last if applicable.

**IF YOU ARE ELIGIBLE FOR MEDICARE AND YOU ENROLL IN MEDICARE+CHOICE, YOU MUST USE NETWORK PROVIDERS AND COMPLY WITH THE MANAGED CARE PROVIDER'S REQUIREMENTS. IF YOU DO NOT, BENEFITS PAID UNDER THIS PLAN WILL BE LIMITED TO THE AMOUNT THAT WOULD HAVE BEEN PAID BY MEDICARE HAD YOU USED A NETWORK PROVIDER AND/OR COMPLIED WITH THE MANAGED CARE PROVIDER'S REQUIREMENTS.**

**TO FACILITATE PLAN PAYMENTS IN THE ABSENCE OF MEDICARE PAYMENTS, IT MAY BE NECESSARY FOR THE TRUSTEES TO ESTIMATE MEDICARE PAYMENTS.**

## COORDINATION OF BENEFITS WITH MEDICARE

Medicare consists of three parts. The first part is officially called Hospital Insurance Benefits for the Aged and Disabled, and is commonly referred to as Part A of Medicare. The second part is officially called Supplementary Medical Insurance Benefits for the Aged and Disabled, and is commonly referred to as Part B of Medicare. The third part is Medicare+Choice, and is commonly referred to as Part C. Part A of Medicare primarily covers Hospital benefits, although it also provides other benefits. Part B of Medicare primarily covers Physician's services, although it, too, covers a number of other items and services. Part C is the managed care program under Medicare. If you are Eligible for Medicare, the Plan's payment is based on both Medicare Part A and Part B benefits.

Typically, you become Eligible for Medicare upon reaching age 65. Under certain circumstances, you may become Eligible for Medicare before age 65 if you are a Disabled worker, dependent widow, or have chronic End-Stage Renal Disease (ESRD). You should be aware that even if you do not choose to retire and do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for both Parts A and B of Medicare. Since Part A of Medicare is ordinarily free, you should apply for it as soon as you are eligible. You will be required to pay a monthly premium for Part B of Medicare.

If you or one of your Dependents are entitled to Medicare due to age, Disability, or End Stage Renal Disease (ESRD), you are required to enroll in Medicare Part A and Part B. The Plan will not pay benefits that exceed the amounts specified in the *Summary Of Benefits*. In addition, the combined amounts paid by Medicare and the Plan will not exceed the eligible expenses incurred as the result of any one Injury or Illness. Benefits paid by Medicare include those that would have been paid if the Eligible Person had properly enrolled when eligible to do so.

If you are Eligible for Medicare due to:

- Age or Disability (other than ESRD) and you are covered as:
  - > A retiree, Disabled Participant, or surviving spouse or Dependent of such Participant, Medicare will be your primary plan and Plan benefit payments will be reduced by the amount of benefits paid (or payable) under Medicare (see *How The Plan Coordinates Benefits With Medicare* on page 80). If you subsequently become entitled to Medicare due to ESRD, Medicare will continue to be your primary plan; or
  - > An active Participant or Dependent of an active Participant, this Plan will be your primary plan and Plan benefit payments will not be reduced. However, if you become entitled to Medicare due to age, you may elect to make Medicare your primary source of coverage. In this instance, the Plan is legally prohibited form supplementing Medicare coverage. If you subsequently become entitled to Medicare due to ESRD, this Plan will continue to be the primary plan for the first 30 months (refer to the following item for more information).
- ESRD, the Plan will be the primary source of coverage for up to the first 30 consecutive months. Beginning in the 31st month, Medicare will become the primary plan and benefit payments under this Plan will be reduced by the amount of benefits paid (or payable) under Medicare (see *How The Plan Coordinates Benefits With Medicare* on page 80).

**YOU, AND THE PLAN, ARE NOT RESPONSIBLE FOR PAYING ANY CHARGES THAT EXCEED LEGAL LIMITS SET BY THE MEDICARE PHYSICIAN PAYMENT REFORM ACT, WHICH LIMITS THE AMOUNT THAT PHYSICIANS CAN BILL MEDICARE PATIENTS FOR A PARTICULAR PROCEDURE OR SERVICE, UNLESS SERVICES ARE PRIVATELY CONTRACTED.**

**YOUR CLAIMS AND YOUR SPOUSE'S CLAIMS (IF HE OR SHE ALSO IS ELIGIBLE FOR MEDICARE) SHOULD BE SUBMITTED TO MEDICARE FIRST.**

If you are eligible for retiree coverage and Medicare is your primary plan, the benefits paid (or payable) under this Plan for services:

- Incurred at a Veterans Administration (VA) facility for non-service connected Disability will be reduced by the amount that would have been paid by Medicare had the services been rendered by a Medicare approved facility.
- Otherwise covered by Medicare, but that are privately contracted with a provider, will be limited to the amount that would have been paid by the Plan had the services been paid by Medicare.

If Medicare is your primary plan, your claims or your spouse's claims (if he or she is Eligible for Medicare) should be submitted to Medicare first. After Medicare pays the claim, submit an itemized statement along with the Medicare Explanation of Benefits to the Fund Office.

## HOW THE PLAN COORDINATES BENEFITS WITH MEDICARE

The Plan's benefit payment coordinates with Medicare's payment. For inpatient Hospital claims, the Plan pays a percentage of Medicare's inpatient deductibles and copayments (the coinsurance percentage is listed on the *Summary Of Benefits* in the back pocket of this booklet). For other Covered Expenses, you pay a percentage (listed on the *Summary Of Benefits* in the back pocket of this booklet) of the total Usual, Customary and Reasonable Charges. Medicare and the Plan then share the remaining percentage amount. Medicare pays a certain percentage, and then the Plan pays the difference. For these expenses, the Plan "carves out" Medicare's payment, as follows:

- Covered charges under this Plan are determined; then
- The amount Medicare pays for these same changes is subtracted from the above; then
- The balance, if any, is the amount used in computing the benefit under this Plan.

### Medicare Coordination Of Benefits Example

Chris is Hospitalized for an Illness. His Hospital and Physician charges are both covered under Medicare and the Plan. Here's how benefits would be coordinated.

| | |
|---|---|
| Chris' Hospital Covered Charges: | $10,000.00 |
| Medicare Pays: | - $9,188.00 |
| Medicare Part A Deductible Chris Is Responsible For Paying: | $812.00 |
| Plan Pays (95%): | - $771.40 |
| Chris Pays: | **$40.60** |
| | |
| Chris' Physician Medicare Approved Covered Charges: | $4,000.00 |
| Medicare Pays 80% | -$3,200.00 |
| **Chris Pay 10% of Medicare Allowed Charges:** | **-$400.00** |
| Plan Pays Balance (not to exceed 90%) | $400.00 |

*This example assumes that this is an assigned claim, which means the provider accepts Medicare.*

**PROTECTED HEALTH INFORMATION (PHI) INCLUDES ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION TRANSMITTED OR MAINTAINED BY THE PLAN.**



## INFORMATION GATHERING

To implement the Coordination of Benefit provisions, the Trustees may release or obtain any information necessary, in compliance with any applicable legislation. Anyone claiming benefits under this Plan must provide any information necessary to implement the Coordination of Benefits provisions or to determine their applicability.

## PRIVACY POLICY

The Plan is required to protect the confidentiality of your private health information (PHI). The privacy rules are effective as of April 14, 2003.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

Your rights under HIPAA include the right to:

- See and copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact the Plan's Privacy Official at the Fund Office.

### USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to:

- Determination of eligibility, coverage, and cost sharing amounts (e.g., cost of a benefit, Plan maximums and copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities, and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to participant inquiries about payments;

- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review, and retrospective review;
- Disclosure to consumer reporting agencies related to collection of premiums or reimbursement. The following PHI may be disclosed for payment purposes:
  - > Name and address;
  - > Date of birth;
  - > Social Security Number;
  - > Payment history;
  - > Account number; and
  - > Name and address of the provider and/or health Plan; and
- Reimbursement to the Plan.

### HEALTH CARE OPERATIONS

Health Care Operations include, but are not limited to, the following activities:

- Quality Assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives, and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;
- Business management and general administrative activities of the entity, including, but not limited to:
  - > Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
  - > Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;
  - > Resolution of internal grievances; and
  - > Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and
- Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500s, SARs, and other documents.

## ADDITIONAL PRIVACY INFORMATION

The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary.

For purposes of this section, the Board of Trustees of the Operating Engineers Local 139 Health Benefit Fund is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor of the following provisions.

- With respect to PHI, the Plan Sponsor agrees:
  - > Not to use or further disclose the information other than as permitted or required by this Summary Plan Description or as required by law;
  - > To ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
  - > Not to use or disclose the information for employment-related actions and decisions unless authorized by the individual;
  - > Not to use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the individual;
  - > To report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
  - > To make PHI available to the individual in accordance with the access requirements of HIPAA;
  - > To make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
  - > To make available the information required to provide an accounting of disclosures;
  - > To make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the Plan with HIPAA; and
  - > If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, the Plan will limit further uses and disclosures to those purposes that make the return or destruction infeasible.
- Adequate separation between the Plan and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:
  - > The Plan Administrator; and
  - > Staff designated by the Plan Administrator.

  The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

  If the persons described above do not comply with this Summary Plan Description, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

For purposes of complying with the HIPAA privacy rules, the Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other Plan functions or benefits.

## BENEFITS PAID WHERE A THIRD PARTY MAY BE LIABLE

Whenever the Fund provides benefits for an Illness, Injury, or death for which a third party may be liable, the Fund may make a claim or take legal action against the third party. This section gives the Plan the right to recover all of the benefits it has paid to you or to those who provided your medical treatment from another payment source or from you if you have received the payment directly. The Plan has the right to recover those payments, whether or not you have been fully paid for your treatment or other expenses from the same Illness or Injury. Throughout this section, the term "you" refers to you or an eligible covered Dependent.

For instance, if you are in an automobile accident, you may receive payment for your medical treatment from an automobile insurance company or from the person who was at fault in the accident. If the Plan paid for your expenses that the automobile insurance company is responsible for, the Plan has the right to recover those expenses from the automobile insurance company or from you if they were paid to you.

### AGREEMENT TO REIMBURSE PLAN FOR OTHER PAYMENTS

Whenever you or your Dependent have an Injury that may be paid for by Another Person or Entity, you (and your Dependent if your Dependent is Injured) must complete a Reimbursement Agreement to receive benefits from the Plan. If your Dependent is a minor or is legally incompetent, you and the person who is legally authorized to act on his or her behalf must complete the Reimbursement Agreement. You and your Dependent must also comply with the following terms:

- You must agree to repay the Plan out of any Recovery or any benefits the Plan has paid because of your Illness or Injury. This provision applies even if the Recovery does not fully pay you for the expenses.
- You will only be required to repay the Plan the amount of the benefits the Plan paid on the claim, or the amount you have recovered, whichever is less, without regard to attorneys fees and expenses you paid to obtain the Recovery.
- The Reimbursement Agreement gives the Plan a lien–or claim–on the money you recover from an Other Source, both to the full extent of the Plan's Subrogation rights and to the full extent of its right to repayment under the Reimbursement Agreement. The lien is valid whether or not the Reimbursement Agreement or the Plan's Subrogation rights are enforceable.
- You must protect the Plan's right to reimbursement for benefits paid and do everything necessary for the Plan's Recovery of benefits. You must assist and cooperate with representatives of the Plan and sign all documents required by the Plan to recover benefits paid by the Plan.
- If you receive a judgment or settlement, you must repay the Plan the lesser of the full amount of benefits paid by the Plan, or the amount of the Recovery. This applies, whether or not the source of the Recovery was legally responsible for paying those expenses. If you do not repay the Plan, the Plan may reduce future benefits for your claims until the Plan has recovered the benefits it paid. The Plan's right to reduce future benefits is in addition to any other legal rights the Plan has to recover benefits.
- You, your Dependent, or your Dependent's representative:
  - > Must not assign to Another Person or Entity your right to recover benefits from an Other Source;
  - > Must obtain the Plan's consent before releasing Another Person or Entity from liability for any Injury; and
  - > Must not interfere with the Plan's claim and lien.

  If you attempt to assign your right to Recovery of benefits, the Plan may take you to court, along with Another Person or Entity to which you assigned your rights, to cancel your assignment and recover the benefits paid by the Plan.

- The Plan is subrogated to your right to recover from an Other Source.
- The Plan is not responsible for legal fees and expenses you pay to obtain a Recovery from an Other Source, unless the Plan has agreed to that in writing.
- The Plan may require your attorney(s) to sign an agreement that they will honor and enforce the terms of the Reimbursement Agreement before the Plan disburses any money received as a Recovery from a Compensable Injury.

### PLAN'S RIGHT OF SUBROGATION

This Plan will be reimbursed for all benefit payments made as the result of Injuries or Illnesses that are caused by the actions of a third party and that give rise to a court ordered financial award or out-of-court settlement to a covered individual from a third party person, party, or tort-feasor. This Plan will provide benefits, otherwise payable under this Plan, to or on behalf of the covered individual only on the following terms and conditions:

- The Plan's right of recovery will be a prior lien against any proceeds recovered by the covered individual, which right will not be defeated or reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No covered individual will incur any expenses on behalf of the Plan in pursuit of the Plans rights; specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right will not be defeated by any so called "Fund Doctrine," "Common Fund Doctrine," or "Attorney's Fund Doctrine."
- Your agreement to repay in the Reimbursement Agreement and the Plan's right of Subrogation are separate and distinct rights and obligations. If either the Agreement or the right of Subrogation fails or is invalid in some way, it will not affect the validity of the other.
- The provisions in the previous section, *Agreement To Reimburse Plan For Other Payments*, also apply to the Plan's right of Subrogation. If you fail or refuse to sign a Reimbursement Agreement, it does not affect the Plan's Subrogation rights or the Plan's right to claim a lien against and collect benefits from any source of possible Recovery.
- The Plan has the right to intervene and participate in any legal action you bring against an Other Source.
- If you fail or refuse to take legal action against an Other Source within a reasonable time, the Plan may do so in your name to recover amounts due under the Plan's right of Subrogation. If the Plan takes the legal action, the Plan has the right to take its expenses, costs, and attorney's fees out of any Recovery or settlement. However, the Plan is not required by this provision to pursue your claim against Another Person.
- If you recover benefits from an Other Source and do not repay the Plan, the Plan may sue you to recover the amount of the benefits paid. The Plan may also reduce any of your future benefits until the Plan is fully repaid, regardless of whether or not the future claim is related to the Compensable Injury.
- If the Trustees determine that Recovery from an Other Source is not possible, the Plan will waive its right to Subrogation and will pay its normal benefits for your claim.

- The Trustees or their authorized representative have the sole discretion to interpret the Plan's Subrogation provisions and to settle any of the Plan's Subrogation claims and liens.
- The Trustees have the sole discretion to determine questions of whether any benefit payment is related to a Compensable Injury. If the Trustees or their representative reasonably request it, you must sign any and all necessary documents, releases, and waivers that relate to their determination.

### COMPENSATED INJURIES

If an Other Source has already paid you for your Injury, the Plan will not begin paying benefits until the total expenses for your Injury exceed the total amount you have recovered from an Other Source.

- Any and all Recovery you receive will first be applied to benefits payable under this Plan.
- The Plan's Subrogation rights are enforceable, regardless of:
  - > Who begins the legal action against Another Person or Entity that is responsible for the Injury;
  - > Who pays the amount of the Recovery;
  - > Whether the Recovery is in the form of a judgment, settlement, or otherwise; or
  - > Whether you receive the Recovery as an employee, Dependent, legally competent or incompetent person or a representative of any such person.
- Nothing in this section will interfere with or decrease the Fund's right to Subrogation for medical expenses that were incurred and paid before you recovered the expenses from your Injury.

### DEFINITIONS

The following definitions apply to the terms used in this section:

- **Another Person** or **Entity** means any individual, corporation, municipality, or other governmental entity, partnership, association, trust, or any other organization, no matter how the person or entity has been identified.
- **An Other Source** means someone other than you or the Plan and includes:
  - > An insurance company that must pay the claims that result from the acts of Another Person, such as for any accident coverage, No-Fault Motor Vehicle Plan coverage, uninsured or underinsured motorist coverage, personal injury protection, homeowners insurance, or school or athletic insurance; or
  - > Another Person or Entity (such as a company, organization, or corporation) that is responsible for the acts of the person that caused your expenses, such as a homeowner or other property owner.

  An Other Source does not include another employer group health plan that covers you, for example, through your spouse's employer, if that coverage is subject to the Coordination of Benefits provisions of this Plan.
- **Compensable Injury** means any Injury for which you or your Dependent may recover from an Other Source or have already been paid by an Other Source before this Plan pays for the same claim.

**PLEASE BE AWARE THAT BENEFITS PAID BY THE PLAN MAY BE RECOVERED FROM YOU, EVEN IF YOU DID NOT RECEIVE SUCH PAYMENT; FOR EXAMPLE, IF PAYMENT WAS MADE TO A PROVIDER OR YOUR DEPENDENT.**

- **Injury** means either an Illness or an Injury, if caused by the actions of Another Person. It also includes conditions that you may develop over time, such as from continued exposure to a harmful agent or a prolonged misdiagnosis of your condition.
- **Recovery** means any payment from an Other Source as a result of an Injury. It includes any judgment, award, or settlement, whether or not the judgment, award, or settlement specifically includes or excludes medical expenses or payments for Disability. This definition applies no matter what the recovery is called. For example, loss, punitive damages, pain and suffering, medical expenses, attorney's fees, costs, etc. are all defined as recoveries.

## RIGHT OF RECOVERY

If the Fund pays more benefits than it is liable to pay for, including, but not limited to, benefits paid in error, the Fund can recover such excess benefit payments from any person, organization, Physician, Hospital, or other health care provider that has received such excess benefit payments.

The Fund can also recover such excess benefit payments from any other insurance company, service plan, or benefit plan that has received such excess benefit payments.

If the Fund cannot recover such excess benefit payments from an Other Source, it can also recover such excess benefit payments from you, including any benefits that may have been paid to one of your Dependents or a provider.

When the Fund requests that you pay a portion of the excess benefit payments, you agree to pay such amount immediately upon notification. The Fund may, at it's option, reduce any future benefit payments for which the Fund is liable under the policy on other claims by the amount of the excess benefit payment, in order to recover such payments. The Fund will reduce benefits otherwise payable for claims until the excess benefit payments are recovered by the Fund.

# ADMINISTRATIVE INFORMATION

IN THIS SECTION >>


INFORMATION ABOUT THE PLAN 88
- Plan Name 88
- Plan Numbers 88
- Plan Year 88
- Plan Sponsor And Plan Administrator 88
  - Board Of Trustees 89
- Administrative Manager 89
- Parties To The Collective Bargaining Agreement 90
- Plan Funding 90
  - Investments 90
  - Self-Funded Benefits 90
  - Insured Benefits 90
- Type Of Plan 91
- Legal Process 91

YOUR ERISA RIGHTS 91
- Receive Information About Your Plan And Benefits 91
- Continue Group Health Plan Coverage 92
- Prudent Actions By Plan Fiduciaries 92
- Enforce Your Rights 93
- Assistance With Your Questions 93


## INFORMATION ABOUT THE PLAN

### PLAN NAME

The Operating Engineers Local 139 Health Benefit Fund.

### PLAN NUMBERS

The Internal Revenue Service assigns an Employer Identification Number (EIN) to organizations sponsoring benefit plans. The EIN number assigned to the Board of Trustees, the sponsor of our plan, is 23-7166771. The Board of Trustees assigns a Plan Number for use in reporting and disclosure filings required under the Employee Retirement Income Security Act of 1974 (ERISA). The Plan Number assigned is 599. Taken together, the Plan's name, number, and the Trustee's EIN identify our Plan with government agencies.

### PLAN YEAR

All records for the Fund are kept on a Plan Year basis. The Plan Year starts on June 1 and ends on May 31.

### PLAN SPONSOR AND PLAN ADMINISTRATOR

The Plan is sponsored and administered by the Board of Trustees. The Board of Trustees is made up of four Employee Trustees (appointed by the Union) and four Employer Trustees (appointed by the Employer Associations). The duties, responsibilities, and authority of the Trustees are explained clearly in the Trust Agreement establishing and governing the administration of the Fund. A copy of the Trust Agreement may be obtained by writing to the Fund Office. The Plan Administrator has full discretionary authority to interpret the Plan and to determine eligibility for participation and entitlement to benefits and its decisions will be final and binding.

If you wish to contact the Board of Trustees, you may use the address, phone numbers, or Internet address below:

Operating Engineers Local 139 Health Benefit Fund
N27 W23233 Roundy Drive
P.O. Box 160
Pewaukee, Wisconsin 53072-0160
(262) 549-9190
(800) 242-7018
www.iuoe139.org

### Board Of Trustees

The current Trustees are:

**Union Trustees**

Darrell J. Kane
Operating Engineers Local 139
5191 Abitz Road
Appleton, Wisconsin 54914

Terrance E. McGowan
Operating Engineers Local 139
4702 South Biltmore Lane
Madison, Wisconsin 53718

Dale A. Miller
Operating Engineers Local 139
N27 W23233 Roundy Drive
Pewaukee, Wisconsin 53072

Terry Pare
Operating Engineers Local 139
1003 South Hillcrest Parkway
Altoona, Wisconsin 54720

**Employer Trustees**

Jack Arseneau
Wisconsin Road Builders Association
1 South Pickney Street, Suite 818
Madison, Wisconsin 53703

Darren Lett
C.R. Meyer & Sons Company
895 West 20th Avenue
Oshkosh, Wisconsin 54903

Edward J. Hayden
Allied Construction Employers Association
17100 West Bluemond Road, Suite 102
Brookfield, Wisconsin 53005

Richard W. Wanta
Wisconsin Underground Contractors' Association, Inc.
2835 North Mayfair Road
Milwaukee, Wisconsin 53222

The Board of Trustees meets periodically to discuss the operation of the Fund. The Trustees make all major decisions regarding benefits, setting of investment policy, and establishing guidelines for administering the Fund. The decisions are made with the interests of Fund Participants in mind and in a manner that does not discriminate in favor of or against any Participant or group. Any action by the Board of Trustees must be voted on and supported by a majority of the Board.

The Board of Trustees has delegated some administrative responsibilities to other individuals or organizations. See the *Important Contact Information* insert to this booklet for a listing of those organizations and their responsibilities.

Each year the Fund's finances are audited by the Fund Auditor. A summary of their report is published annually and distributed to all Fund Participants.

### ADMINISTRATIVE MANAGER

Certain record keeping and claims processing duties are performed by the Administrative Manager, at the request of the Trustees. The Administrative Manager is Carday Associates, Inc., a nationally known administration firm.

Administration is handled from the Fund Office at:

N27 W23233 Roundy Drive
P.O. Box 160
Pewaukee, Wisconsin 53072-0160

The office telephone number is (262) 549-9190 or toll-free at (800) 242-7018. You are invited to visit this office Monday through Friday from 8:00 a.m. to 4:30 p.m. or feel free to visit the Web site at www.iuoe139.org at any time.

## PARTIES TO THE COLLECTIVE BARGAINING AGREEMENT

The Fund is the result of collective bargaining agreements between Local 139 of the International Union of Operating Engineers and principally the following Employer Associations:

- Wisconsin Road Builders Association;
- Wisconsin Chapter, The Associated General Contractors of America, Inc.;
- Wisconsin Underground Contractors Association, Inc.;
- Allied Construction Employers Association, Inc.; and
- Other Employers.

Upon written request to the Fund Office, you or your beneficiaries may receive information on whether or not a particular employer is authorized to contribute to the Fund. In addition, a complete list of all contributing Employers is available for review at the Fund Office. You may also obtain a copy of the collective bargaining agreements by writing to the Fund Office.

## PLAN FUNDING

The Health Benefit Fund has been created to provide health care coverage to Eligible Persons. A portion of the negotiated wage package determined by collective bargaining between Local 139 and your Employer has been designated for the Fund to provide this coverage.

This is the primary source of income to the Fund—income generated from hours worked by Active employees. Several collective bargaining agreements establish the amount that Employers must contribute for every hour worked by an Active Participant. As a Participant, you are not required to make contributions to the Fund unless you lose your eligibility. Then, if permitted, you may make self-payment contributions to keep benefits in force.

In addition to Employer contributions, monthly self-payment contributions for retiree coverage are deposited in the Trust Fund.

### Investments

The money in the Fund is invested by the Trustees. Earnings from investments are an additional source of income to the Fund for benefits. It is the Trustees' responsibility to invest the money in a way that keeps a reasonable balance between investment safety and investment return, while providing enough cash to pay day-to-day claims. The money in the Fund is invested and paid out for the exclusive benefit of Fund Participants and their beneficiaries.

### Self-Funded Benefits

Most of the benefits provided through the Fund are self-funded. This means your Employer's contributions and any self-payment contributions are made directly to the Fund, and benefit payments to you or your beneficiaries are made directly from the Fund. There is no insurance company in between to collect premiums and pay benefits.

This procedure helps keep costs down and enables the Fund to provide more money for benefits. In addition, it means that all of us are part of a self-sufficient group. This places responsibility upon all of us, both Trustees and Participants, to spend the Fund's money for benefits with the same care and cost consciousness we would use in spending our own money.

### Insured Benefits

Because certain benefits typically require catastrophic coverage, it is more economical for the Fund to offer these benefits through an insurance policy. Insurers collect premiums from the Fund and pay benefits. Certain transplant benefits are covered by a policy purchased from BCS Insurance Company, 676 North St. Clair Street, Chicago, Illinois 60611-2997. The policy number is OTBM-29104.

In addition, mental health and substance abuse treatment benefits are covered by a policy purchased from Health Management Center (HMC), 2600 North Mayfair Road, Suite 490, Wauwatosa, Wisconsin 53226. The group number is 4416.

### TYPE OF PLAN

The Health Benefit Fund is classified with the U.S. Department of Labor as a welfare benefit plan providing medical, dental, vision, disability, and death benefits.

### LEGAL PROCESS

Service of legal process may be delivered to one of the Trustees individually or to the:

Board of Trustees
Operating Engineers Local 139 Health Benefit Fund
Office of the Administrative Manager
N27 W23233 Roundy Drive
Pewaukee, Wisconsin 53072-0160

## YOUR ERISA RIGHTS

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

### RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD (the Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to furnish to each Participant.

## CONTINUE GROUP HEALTH PLAN COVERAGE

You also have the right to:

- Continue health care coverage for yourself, spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event (You or your Dependents may have to pay for such coverage; review this SPD and any documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.); and
- Reduce or eliminate exclusionary periods of coverage for Preexisting Conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage (HIPAA), free of charge, from your group health plan or health insurance issuer when:
  - > You lose coverage under the Plan;
  - > You become entitled to elect COBRA Continuation Coverage; or
  - > Your COBRA Continuation Coverage ends.

  You must request the Certificate of Creditable Coverage (HIPAA) before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a Preexisting Condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

## PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## ENFORCE YOUR RIGHTS

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

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

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

## ASSISTANCE WITH YOUR QUESTIONS

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

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

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by:

- Calling (866) 444-3272;
- Sending electronic inquires to www.askebsa.dol.gov; or
- Visiting the Web site of the EBSA at www.dol.gov/ebsa.

# GLOSSARY

Terms defined in the glossary are capitalized throughout this booklet.

**Accident** is an immediate unforeseen event caused by external trauma to the body.

**Acute Rehabilitation Facility** is a facility that provides, for compensation, rehabilitation care services on an inpatient basis for acute care, which is care of a short duration for Illnesses or Injuries that are rapid and abbreviated in onset. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients Disabled by disease or Injury to achieve the highest possible level of functional ability. Services are by provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

**Ambulatory Care Center** or **Ambulatory Surgical Center** is a lawfully operated clinic that maintains and operates facilities similar to a Hospital emergency room. In addition, an Ambulatory Surgical Center is a facility equipped to perform surgeries on a same-day basis and that:

- Is established, equipped, and operated in accordance with the laws of the jurisdiction in which it is located, primarily for the purpose of performing surgical procedures;
- Is operated under the supervision of a licensed Doctor of Medicine (MD) or Doctor of Osteopathy (DO), who is devoted full time to such supervision, and permits surgical procedures to be performed only by a legally qualified Physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one Hospital (as defined) in the area;
- Requires that, in all cases other than those requiring local infiltration anesthetics, a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure;

- Provides at least two operating rooms and at least one post-anesthesia recovery room and:
  - > Is equipped to perform diagnostic x-ray and laboratory examinations; and
  - > Has available to handle foreseeable emergencies, trained personnel and necessary equipment, including, but not limited to, a defibrillator, a tracheotomy set, a blood bank, or blood supply;
- Provides full-time services of one or more registered nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room; and
- Maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require post-operative Confinement.

**Calendar Year** is January 1 through December 31.

**Complications of Pregnancy** is, before the pregnancy ends:

- Acute nephritis;
- Nephrosis;
- Cardiac decompensation;
- Missed abortion;
- Hyperemesis gravidarum;
- Eclampsia of pregnancy; and
- Other pregnancy-related conditions that are as medically severe as the above.

The following conditions are defined as Complications of Pregnancy at termination:

- Ectopic pregnancy; and
- Miscarriage or spontaneous abortion where a live birth is not possible.

**Confined** or **Confinement** is the period starting with a Participant's admission on an inpatient basis to a Hospital or other facility for treatment of an Illness or Injury. Confinement ends with the Participant's discharge from the same Hospital or other facility. If the Participant is transferred to another Hospital or other facility for continued treatment of the same or related Illness or Injury, it is still considered one Confinement.

**Cosmetic** or **Reconstructive Surgery** is any surgical procedure performed primarily to:

- Improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or
- Prevent a mental or nervous disorder through a change in bodily form.

Cosmetic or Reconstructive Surgery does not include surgery following a mastectomy, see page 38.

**Covered Expense** includes expenses covered under the Plan for treatment, care, services, or supplies, but only to the extent that:

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

**Custodial Care** is any care intended primarily to help a Disabled person meet basic personal needs when:

- There is no plan of active medical treatment to reduce the Disability; or
- The plan of active medical treatment cannot reasonably be expected to reduce the Disability.

**IF A CHILD, WHILE UNDER AGE 25, RETURNS TO SCHOOL AS A FULL-TIME STUDENT, HE OR SHE IS PERMITTED TO REGAIN DEPENDENT STATUS. HOWEVER, THE PLAN'S PREEXISTING CONDITION PROVISION MAY APPLY (SEE PAGE 6).**

**Dental Hygienist** is any person who currently is licensed (if licensing is required in the state) to practice dental hygiene by the governmental authority having jurisdiction over the licensure and practice of dental hygiene, and who works under the supervision of a Dentist.

**Dental Procedures:**

- **Diagnostics** are procedures used by a Dentist to assist and evaluate an oral examination, including full-mouth or panoramic x-rays and bite-wing x-rays (cavity detection).
- **Endodontics** is treatment of the inner, living portion of the tooth, including root canal therapy and treatment of pulp diseases.
- **Orthodontics** is a procedure to straighten teeth or correct malocclusion (incorrect bite), including diagnosis and treatment for patients under age 19.
- **Periodontics** is treatment for disease of teeth-supporting tissues, including treatment of gum diseases.
- **Preventive Services** are routine examinations and cleaning procedures to prevent the occurrence of dental abnormalities and oral disease.
- **Prosthodontics** is procedures associated with the construction, insertion, and repair of dentures and bridges, including initial insertion of fixed bridges or partial or full dentures.
- **Restorative Procedures** are services to restore diseased or damaged teeth, including:
  - > Direct (regular) fillings such as amalgam, silicate, acrylic synthetic porcelain, and composite fillings;
  - > Indirect filling such as precious metal cast restorations; and
  - > Inlays, onlays, and crowns when Medically Necessary.

**Dentist** is any person who currently is licensed to practice dentistry by the governmental authority having jurisdiction over the licensure and practice of dentistry, and who is acting within the usual scope of such practice.

**Dependent** is an individual, as defined below, who is eligible for certain benefits from the Fund. In general, covered Dependents include your:

- Spouse; and
- Unmarried children through attainment of age 19 (or through attainment of age 25 provided their primary occupation and activity is that of full-time students in an accredited school, and they remain primarily financially dependent upon you).

If your child is a full-time student and you want to continue his/her coverage beyond the attainment of age 19 (through attainment of age 25), you may elect to make a monthly contribution per student to continue coverage. You will be required to submit documentation verifying his/her status as a full-time student at an accredited school.

If your child is primarily financially dependent on you and incapable of self-sustaining employment due to a mental or physical handicap, such child may be covered beyond age 19, provided the condition existed before age 19.

Proof of the incapacity must be submitted to the Trustees within 31 days of the date the Dependent child's coverage would otherwise end or within 31 days after he or she initially becomes eligible for benefits from the Fund.

A child is considered an eligible Dependent if he or she is:

- Dependent on you for support and maintenance;
- Living with you in a regular parent-child relationship; and
- Claimed as an exemption by you for income tax purposes.

A Dependent child may include your:

- Natural born child;
- Stepchild;
- Legally adopted child or child placed with you for adoption; or
- Child for whom you are the legal guardian, providing the child is living with you in a manner calculated to obtain dependent status for income tax purposes. You must file a certified copy of the guardianship court order with the Trustees, and furnish tax filings demonstrating that the income tax requirements are satisfied.

**Disabled** or **Disability** means you or your Dependent is prevented from performing the major duties of your occupation solely because of a non-occupational Illness or Injury. Injuries on the job are not covered.

**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 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 judgement of the Physician.

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

**Eligible for Medicare** means you are age 65 or older or are Disabled and have been receiving Social Security benefits for 24 months or you meet the requirements relative to End-Stage Renal Disease.

**Eligible Person** is either the eligible employee or the eligible Dependent.

**Enrollment Card** information is needed by the Fund Office to provide benefits to you. Your Dependents become eligible for coverage on the same date you become eligible, or if later, on the date you acquire an eligible Dependent. However, if you do not notify the Fund Office within 30 days of when your new Dependent becomes eligible, your Dependent's coverage will not begin until the first day of the month after you complete and return the Enrollment Card to the Fund Office adding the Dependent. No benefits will be processed by the Fund Office without this information. This card also includes your beneficiary designation for the Death Benefit provided by the Fund. It is your responsibility to notify the Fund Office of any changes.

**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.

**Extended Care Facility** is an institution that is primarily engaged in providing skilled nursing, rehabilitative, and related services to inpatients. Such care must be provided under the supervision of professional medical personnel who are duly licensed and who practice according to general medical ethical standards. Further, such institution must also be licensed or approved by the state or locality in which it operates, according to the licensing requirements of that area. However, any institution that operates primarily for the care of mental diseases or tuberculosis is not considered to be an Extended Care Facility.

**Freestanding Surgical Center** is a center that:

- Has an operating room, recovery room, and all required equipment for use before, during, and after surgery;
- Is supervised by an organized medical staff;
- Has a contract with a nearby Hospital for acceptance of patients who require Hospital care after surgery; and
- Is not a private office or clinic of one or more Physicians.

**Home Health Care Agency** is a public or private organization that is primarily engaged in providing skilled nursing and therapeutic services on an at-home basis. A Home Health Care Agency must be supervised by professional medical personnel and be licensed or approved by the state or locality in which it operates.

**Hospice** is an agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, and social care for terminally ill persons assessed to have a life expectancy of six months or less. The agency or organization must:

- Be certified by Medicare;
- Be licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, the agency or organization must:
  - > Provide 24 hour-a-day, 7 day-a-week service;
  - > Be under the direct supervision of a duly qualified Physician;
  - > Have a full-time administrator;
  - > Have a nurse coordinator who is a registered nurse, with experience involving care for terminally ill patients;
  - > Have a main purpose of providing Hospice services;
  - > Maintain written records of services provided to the patient; and
  - > Maintain malpractice insurance coverage.

A Hospice that is part of a Hospital will be considered a Hospice for the purposes of this Plan.

**Hospice Program** is a program that:

- Has received a certificate of need from the state or locality in which it operates to provide hospice care in a given area;
- Is eligible to satisfy accreditation requirements as developed by Medicare and/or the Joint Commission on the Accreditation of Health Care Organizations; and
- Meets the following criteria:
  - > The patient and family are seen as a unit of care;
  - > An integrated, centralized administrative structure ensures continuity of care for home care and inpatient care;
  - > There is direct provision of care by a team consisting of Physicians, nurses, social workers, chaplains, and volunteers;
  - > Volunteers are used to assist paid staff members; and
  - > 24-hour-a-day, 7-day-per-week service is available.

**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 or drug addicts.

Hospital also means an approved public or private treatment facility licensed by the state of Wisconsin for the treatment of alcoholism.

For the purpose of mental or nervous disorders, Hospital means a place, other than a convalescent, nursing, or rest home, that:

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

**Illness** or **Sickness** is a disease, disorder, or condition (including pregnancy, childbirth, and any related conditions) that requires treatment by a Physician. Expenses related to tubal ligations and vasectomies are covered as an Illness or Sickness.

**Initial Eligibility** means you become eligible to receive benefits on the first of the month after a Work Quarter in which the Fund received at least 300 hours of Employer contributions made on your behalf. Initial Eligibility cannot be established as a result of reciprocity hours transferred from another Fund.

The initial period of eligibility is five months. However, all newly eligible Participants and their Dependents are subject to the Preexisting Condition provision. See pages 4-11 for more information.

**Injury** is an accidental bodily injury that requires treatment by a Physician and that results in loss independently of Illness or other causes.

**Intensive Care Unit** is a special area of a Hospital, exclusively reserved for critically Ill patients requiring constant observation, which in its normal course of operation provides:

- Personal care by specialized registered professional nurses and other nursing care on a 24-hour-a-day basis;
- Special equipment and supplies that are immediately available on a standby basis; and
- Care required but not rendered in the general surgical or medical nursing units of the Hospital.

The term Intensive Care Unit also means an area of the Hospital designated and operated exclusively as a coronary care unit or cardiac care unit.

**Lifetime** means, when in reference to benefit maximums and limitations, while covered under the Operating Engineers Local 139 Health Benefit Fund. Under no circumstances does Lifetime mean "during the lifetime of the covered Participant."

**Medically Necessary** or **Medical Necessity** means that a specific service or supply is required to treat your condition. Medically Necessary expenses include expenses that:

- 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;
- Are in accordance with the acceptable standards of community practice; and
- Could not have been omitted without adversely affecting either you or your eligible Dependent's condition or quality of medical care.

Inpatient care in a Hospital is Medically Necessary only if treatment for the Illness or Injury cannot be provided safely on an outpatient basis.

A service or supply **is not** automatically considered Medically Necessary just because it is prescribed by a Physician or other medical provider.

**Medicare** is a health care program for the aged and disabled, established by Title XVIII of the Social Security Act of 1965, as amended.

**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.

**Occupational Therapy** or **Physical Therapy** is therapy provided by a registered physical therapist or registered or state-licensed occupational therapist for short-term, non-maintenance therapy rendered for the purpose of physical restoration of a physical Disability for which there is a reasonable expectation of significant improvement as determined by the Plan. Services must be ordered by a Physician under an individual treatment plan that is designed to improve the patient's condition through short-term care.

**Optician, Optometrist,** or **Ophthalmologist** is any person who is qualified and currently licensed (if licensing is required in the state) to practice each such profession by the appropriate governmental authority having jurisdiction over the licensure and practice of such profession, and who is acting within the usual scope of such practice.

**Oral Surgery** includes surgical removal of teeth or multiple extractions requiring Hospital Confinement, removal of impacted teeth, soft tissue, alveolectomy, gingivectomy, apicoectomy, torus palatines, torus mandibulous, frenectomy, excision of cysts, osteoplasty, and stomatoplasty.

**Other Group Plan** is any plan, policy, contract, or other arrangement for benefits or services that provides benefits or services 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, Blue Cross/Blue Shield, individual practice, or other prepayment coverage;
- Health Maintenance Organizations;
- Labor-management trusteed, union welfare, employer organization, or employee benefit organization plans; or
- Government programs or coverage required or provided by any statute.

**Outpatient Psychiatric Facility** is a Hospital or a community mental health center, a day care center, or a night care center associated with a Hospital and licensed as required by applicable law. These facilities do not include institutions or facilities primarily engaged in providing services that are custodial, recreational, social, or educational in nature. An approved Outpatient Psychiatric Facility will be recognized only if there is a psychiatric Physician present in the facility on a regularly scheduled basis who assumes the overall responsibility for coordinating the care of all patients. Services must be available through the professional staff of the facility, as needed, from a psychiatric Physician, clinical psychologist, registered nurse, and psychiatric social worker. Emergency medical care must be accessible through formal agreement with the Hospital.

**Participant,** as used in most contracts and by this Plan, is any person who qualifies for coverage by virtue of employment (including retired employees) and/or union membership (as opposed to a Dependent, who qualifies for coverage by virtue of his or her relationship to a Participant).

**Participant Classes** are defined under this Plan as:

- Actives—eligible active employees;
- Non-Bargaining Unit Employees—eligible employees who are not performing work under a collective bargaining agreement, but whose Employer is signatory to a Non-Bargaining Unit Agreement with the Trustees of the Fund that allows for their participation;
- Retired—early retirees (under age 65), regular retirees (over age 65), surviving spouses, and totally and permanently Disabled Participants; and
- COBRA—any Participant or Dependent who has had a "qualifying event," as described in the Consolidated Omnibus Budget Reconciliation Act, who has elected such coverage, and is making the required premium payment for such coverage.

**Period of Disability** is the continuous period during which you are Disabled. See page 62 for more information.

**Physician** is a person who is licensed by the governmental authority having jurisdiction over such licensure to practice medicine and who is acting within the scope of such license. This definition includes chiropractors, osteopaths, chiropodists, podiatrists, Optometrists, licensed clinical psychologists, psychiatrists, Dentists, dental surgeons, and approved Christian Science practitioners.

**Plan Year** or **Fiscal Year** is June 1 through May 31.

**Preexisting Condition** is any Illness or Injury for which the covered person or Dependent has received medical care, treatment, service, or consultation within six months before the effective date of that person's coverage under this Plan. Care means the diagnosis, treatment, or the presence of symptoms that would cause a prudent person to seek care whether or not care was sought.

The Preexisting Condition clause does not apply:

- After a Participant has been covered under the Plan for six consecutive months;
- After an eligible Dependent has been covered under the Plan for 12 consecutive months;
- To pregnancy; or
- To children who have been adopted or placed in your home for the purpose of adoption.

The Comprehensive Medical Benefits plan includes a Preexisting Condition provision. All newly eligible Participants and their Dependents, as well as all reinstated Participants, who may have gained eligible Dependent status by virtue of a change in the marital status of the Participant, or as a result of a QMCSO, are subject to this exclusion.

However, the preceding time periods will be reduced by the number of days you were covered under prior coverage, excluding coverage before any break in your prior health insurance coverage of 63 days or more. You will need to submit a Certificate of Creditable Coverage (HIPAA) from your prior health care coverage to the Fund Office.

**Preferred Provider** is any of the following who alone, or as part of a group, enter into a contract with the Trustees 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, Dentist, 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 this Plan.

Current types of Preferred Providers include the following:

- Preferred Provider Hospital or Contract Hospital is any of the Hospitals that contract with the Trustees directly or through their agents from time to time and that are named in this SPD; and
- Preferred Provider Pharmacy is any of the pharmacies that are party to a contract with the Trustees.

**Prescription** is 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 medications may be prescribed.

Prescription will also include the following diabetic supplies provided on the written order of a legally qualified Physician or surgeon:

- Insulin;
- Insulin syringe;
- Needles;
- Sugar test tablets;
- Sugar test tape;
- Acetone test tablets;
- Benedict's solution or equivalent; and
- Swabs and alcohol wipes.

**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.

**Skilled Nursing Facility** is a facility that is primarily engaged in providing skilled nursing and related services on an inpatient basis to patients requiring 24-hour-a-day skilled nursing services but not requiring Confinement in an acute care general Hospital. Such care is rendered by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- Minimal care, Custodial Care, ambulatory care, or part-time care services; or
- Care or treatment of mental Illness, substance (alcohol or drug) abuse, or pulmonary tuberculosis.

**Trustees** are the Trustees of the Operating Engineers Local 139 Health Benefit Fund.

**Trust Fund** or **Fund** is the entire trust estate of the Operating Engineers Local 139 Health Benefit Fund as it may, from time to time, be constituted, including policies of insurance, investments and the income from investments, Employers' contributions, self-payment contributions, and other assets, property or money received by or held by the Trustees for the uses and purposes of this Fund.

**Usual, Customary and Reasonable Charges** is the usual, customary and reasonable fee or charge for the services rendered and the supplies furnished in the area that such services are rendered or supplies are furnished, provided such services and supplies are recommended and approved by a Physician or surgeon other than an Eligible Person.

The Health Benefit Fund determines Usual, Customary and Reasonable Charges based on data obtained from sources, such as MEDICODE, HIAA, and other schedules for relevant zip code areas at a percentile that the Trustees adopt.

A charge is considered to be:

- Usual if it is the fee charged by a provider to the majority of patients for a given service, supply, medication, or equipment;
- Customary if it is the fee charged by the majority of providers within the same general geographic area for similar care; and
- Reasonable if the fee charged 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 Charge. This way you are aware, in advance, if there are any amounts that exceed the Usual, Customary and Reasonable Charge amounts for which you will be held responsible.

**OPERATING ENGINEERS LOCAL 139**
**HEALTH BENEFIT FUND**

N27 W23233 ROUNDY DRIVE
P.O. BOX 160
PEWAUKEE, WISCONSIN 53072-0160
(262) 549-9190
(800) 242-7018
WWW.IUOE139.ORG

08.03/15M
FPO