Welfare Fund

Summary Plan Description

Local 14-14B

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Introduction

The International Union of Operating Engineers Local 14-14B Welfare Fund was established on March 15, 1976 to provide health care benefits to members and their families who are eligible for comprehensive health care coverage through this Plan. The Local 14-14B Welfare Fund is financed completely by fringe benefit contributions made by contributing employers pursuant to applicable collective bargaining agreements.

The Board of Trustees is pleased to present you with this new Summary Plan Description (SPD) which highlights the hospital, medical, prescription drug, dental, vision, disability, death and accidental death and dismemberment benefits provided by the Plan. The Plan described in this document is effective January 1, 2007 (except for those provisions that specifically indicate other effective dates) and replaces all other Plan documents/Summary Plan Descriptions previously provided to you.

Please read this SPD carefully and keep it handy for future reference. If you have questions, contact the Fund Office by phone at (718) 939-1489 or in writing at 141-57 Northern Boulevard, Flushing, NY 11354.

Eligibility for Coverage

Members. You are eligible to participate in the Plan if you work at least 250 hours in covered employment with a contributing employer in a four-month coverage period (also called a Benefit Fund Stamp Redemption period; see page 5 for details). There are three four-month coverage periods: March-June, July-October and November-February. Once you have worked 250 hours in a four-month coverage period and redeem stamps representing those hours worked (the 250 hours must be current; no credit is given for "old" stamps), you will be eligible for benefits under the Plan. If you lose your stamps, please contact the Fund Office.

"Covered employment" is work covered by a collective bargaining agreement between your employer and the Union. The collective bargaining agreement requires your employer to contribute to the Plan on your behalf.

Union and Fund Office Staff. Union and Fund Office employees must work 7½ weeks (250 hours) to become eligible for Local 14-14B Welfare Fund benefits. After meeting initial eligibility, he/she must continue to work a 35- or 40-hour week (depending on job title). Please contact the Fund Office for more details.

Owner/Operators. Local 14-14B members who are Owner/Operators are required to contribute 667 hours in Benefit Fund Stamps per redemption period. Failure to contribute this amount in any redemption period will result in a loss of eligibility for coverage. For a copy of this coverage policy, you may contact the Fund Office.

Members working out of town—reciprocity agreements. The Local 14-14B Welfare Fund has a reciprocal agreement with the Welfare Funds of the Northeastern District of the IUOE (the Northeastern District). This agreement was established in order to preserve eligibility and benefits for you as a participant in your home Welfare Fund, regardless of where you may work in the Northeastern District, provided you are working for a contributing employer of the out-of-town Welfare Funds. The Northeastern District is covered by the following Welfare Funds:

Local 4 – Boston, MA
Local Unions 17, 106, 463, 545, and 832 – Upstate NY
Local 15 – New York, NY
Local 25 – Manalapan, NJ
Local 57 – Providence, RI
Local 542 – Fort Washington, PA
Local 66 – Pittsburgh, PA
Local 98 – East Longmeadow, MA
Local 137 – Briarcliff Manor, NY
Local 138 – Long Island, NY
Local 478 – Hamden, CT
Local 825 – Springfield, NJ and Orange and Rockland Counties, NY

Transferred Members. If you transfer from any of the local unions that make up the Northeastern District, you are eligible to receive welfare benefits under this Plan in accordance with the reciprocity agreement with the Northeastern District or any other local union of the IUOE that may enter into a reciprocity agreement with the Welfare Fund at a later date. Under the reciprocity agreement, your original local union's welfare coverage will be primary (pays first) and the Local 14-14B Welfare Fund coverage will be secondary until the primary coverage has been exhausted. Contact your local Fund Administrator for details.

New York City Workers. Local 14-14B Operating Engineers who are employed by the City of New York are eligible for the same optical benefits that are available to Local 14-14B members (see page 36 for a full description of these benefits) as well as for supplemental benefits through the Welfare Fund. These supplemental benefits are three Dental Benefit options, and a $5,000 Death Benefit. To the extent that City workers are covered for the same type of benefit by both the City's health plan and the Local 14-14B Welfare Fund, the City coverage will be primary (pays first) and the Local 14-14B Welfare Fund's coverage will be secondary. City workers who also meet the regular eligibility requirements for Local 14-14B Welfare Fund coverage (250 hours in covered employment with a contributing employer during a four-month coverage period) will receive full benefits through the Local 14-14B Welfare Fund. The City benefits will be primary and the Local 14-14B Welfare Fund's benefits will be secondary for these individuals. City workers should refer to the separate benefit brochures and other descriptive materials for information on these supplemental benefits.

When Coverage Begins

Once you have met the initial eligibility requirements, benefits begin on the first day of the first month of the following coverage period for the period listed below:

Hours worked in a four-month coverage period (stamp redemption month—see page 4 for details)	Coverage will last for:
250 hours	One coverage period for a four-month total.
500 hours	Next two coverage (current Benefit Fund Stamp Redemption) periods, for an eight-month total.
750 hours	Next three coverage (current Benefit Fund Stamp Redemption) periods, for a 12-month total.

Note: *You can never be covered for more than one year ahead.*

For example. David first works 300 hours in covered employment during the months of December 2005, January 2006 and February 2006. David's Local 14-14B Welfare Fund coverage becomes effective March 1, 2006 and continues through June 30, 2006 (four months total). He then works 600 hours in covered employment during the period of March 1, 2006 through June 30, 2006. David's coverage continues through February 28, 2007 (eight months total).

Benefit Fund Stamp Redemption Periods. You will receive stamps for the hours worked in covered employment with a contributing employer. You must redeem stamps with the Fund Office in order to establish your coverage eligibility. You must submit stamps to the Fund Office during the designated Benefit Fund Stamp Redemption months of March, July and November.

Dependent Eligibility

Your dependents are eligible for Plan coverage when you are eligible, provided you enroll them. When you lose eligibility, your dependents also lose their coverage.

Your eligible dependents include:

- the spouse to whom you are legally married;
- your unmarried children until the end of year in which they turn 19 years of age (whether or not they are a student); and
- your unmarried children over 19 years of age, and until the end of the year they turn 25 years of age, who are enrolled as full-time students in an accredited school, college or university, and who are dependent on you for financial support.

"Children" include natural children, legally adopted children, legally adopted stepchildren, children placed with you for adoption, and children, including stepchildren, for whom you have legal guardianship.

In order for the Plan to consider a child an eligible dependent, the child must have the same principal place of residence as you for over half of the year, and must be dependent on you for over half of his/her support. Proof of such residency and support must be furnished to the Plan upon request.

The requirements that you provide over half of the child's support, and that the child have the same principal residence as you for over half of the year will not apply if: (i) you and the child's other parent are divorced or legally separated under a decree of divorce or separate maintenance, separated under a written separation agreement, or live apart at all times during the last six (6) months of the calendar year; (ii) you and the child's other parent provide over half of the child's support; and (iii) the child is in the custody of one or both parents for more than half of the calendar year.

Handicapped children. Extended coverage is available for an unmarried child who is over age 19, cannot work and depends on you solely for support because of a mental, developmental or physical disability or illness and became so disabled before reaching age 19. You must provide proof to the Fund Office that your child's disability began before the child reached age 19 and you must do so no later than 31 days after the child's 19th birthday. For all handicapped children, the Fund Office periodically requires substantiation of the child's continued handicap, which may include a physical examination and proof that the child remains your qualified dependent. Without this proof, coverage may be terminated.

Pensioners. If you retire at age 62 with active medical benefits, you will continue to receive medical benefits (to a certain maximum). Pensioners are also eligible for a death benefit, prescription drug benefits and certain supplemental Medicare benefits. See page 10 for more information.

Enrolling for Coverage

You (the member) are automatically enrolled for coverage when you first become eligible for benefits. However, the Fund Office will still send you an enrollment card. You should complete the enrollment card, including the beneficiary designation, and return it to the Fund Office to ensure it has the proper information on file for you. If you have eligible dependents, you must enroll them when you are first eligible in order for them to be covered. If the Fund Office does not receive a completed enrollment form and the documentation listed below, your dependents will not be eligible for benefits. If you acquire a new dependent after you are initially eligible for benefits, you will need to enroll your new dependent when you add him or her, as described in the "Special Enrollment" section below. When you first enroll or add a new dependent for coverage, you must provide the Fund Office with proof of dependent status.

The Fund Office will accept a copy of any of the following documents as proof of dependent status:

- **Spouse (Marriage):** copy of the certified marriage certificate and Social Security card. If your spouse is employed, you must provide the Fund Office with a letter from your spouse's employer stating that there is no other insurance available. If other coverage is available and your spouse is enrolled, the Fund Office must receive a copy of both sides of the insurance card.
- **Child (Birth):** copy of the certified birth certificate and Social Security card.
- **Step-Child:** copy of divorce decree from the mother to determine which parent is responsible to provide medical coverage.
- **Adoption or placement for adoption:** court order signed by a judge.
- **Full-time student status:** Birth certificate (if not already on file), a signed statement or letter from the school's Registrar's office and a copy of your tax return listing your dependents.
- **Disabled Dependent Child:** Current written statement from the child's physician indicating: (1) the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically handicapped (as that term is defined in this document); (2) an assertion that the child is incapable of self-sustaining employment as a result of that handicap; and (3) an assertion that the child is dependent chiefly on you and/or your spouse for support and maintenance.

You may also be required to submit tax returns identifying dependent status or a Qualified Medical Child Support Order (QMCSO) at the request of the Fund Office.

If your spouse is covered under another group health plan, you must report that other coverage to the Fund Office. If your spouse has other coverage and is offered an incentive to opt out of that plan, he/she may not waive that coverage and continue to be covered by this Plan. The amount of benefits payable under this Plan will be coordinated with your spouse's other coverage.

Special Enrollment

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll that dependent. You must complete an enrollment card and provide proof of dependent status within 30 days after the marriage, birth, adoption or placement for adoption, as described on this page.

If you are declining enrollment for (or do not enroll) your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage) and complete an enrollment card to enroll the dependents.

To request special enrollment or obtain more information, contact the Fund Office.

Start of Coverage for Dependents

Provided you properly enroll them, your dependents will be eligible for benefits when you are initially eligible.

If you later add a dependent, your newborn biological child and adopted newborns will be covered from the date of birth (provided you enroll the baby within 30 days). Your adopted dependent child will be covered from the date that child is adopted or "placed for adoption" with you, whichever is earlier. A child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. A child who is placed for adoption with you within 30 days after the child was born will be covered from birth if you comply with the Plan's requirements for obtaining coverage for a newborn dependent child. However, if a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

Coverage for your new spouse begins on the day you marry, provided you properly enroll your spouse within 30 days of your marriage.

Late Enrollment

If you do not enroll your dependents when first eligible, you may enroll them late but coverage will not begin until the first of the month following the month in which the Fund Office receives your completed enrollment form (and the necessary documentation). If you do not enroll your dependents as described in this section, your claims may be denied until the Fund Office receives your enrollment material.

When Coverage Ends

Benefits terminate on the last day of the last month of the coverage/redemption period when you:

- fail to work at least 250 hours during a coverage/redemption period for a contributing employer; or
- you enter active military service that lasts more than 31 days (see page 9 for more information on USERRA).

When Coverage Ends for Your Dependents

Coverage ends for your dependents when your coverage ends.

In addition, coverage ends for your spouse when you and your spouse are legally divorced and the divorce becomes final. When coverage ends for your spouse, 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 for your spouse to obtain COBRA Continuation Coverage (see page 11). At this time, you may also want to review your beneficiary designation for your death benefit and AD&D benefits, if eligible.

Your child(ren) is no longer eligible for coverage when he or she:

- marries;
- no longer depends on you for support;
- reaches the end of the year in which he or she turns age 19 (age 25 if a full-time student).

Your child may elect to continue coverage by making COBRA self-payments for up to 36 months (see page 11). The Fund Office tracks when a child reaches the limiting age along with student status and will notify you when coverage for your child ends. However, it is ultimately your responsibility to notify the Fund Office of any of the above that would cause a child not to be eligible in order to protect his or her COBRA rights.

Please note that you will be responsible for reimbursing the Fund for any claims that are paid on behalf of your dependent child or spouse who is no longer an eligible dependent (including those that fail to maintain full-time student status) and continues to be covered by the Plan.

Reinstatement of Coverage. If your benefits terminate, your eligibility will be reinstated on the first day of the month after the coverage/redemption period in which you once again meet the eligibility requirements.

Keeping the Fund Office Informed

The best way to ensure fast and accurate claims payment is to make sure the Fund Office has the most up-to-date information for you and your eligible dependents. Please contact the Fund Office whenever you or your spouse have a change in name, address, telephone number or e-mail address, marital status (marriage, legal separation or divorce), add an eligible dependent, or if you or your spouse die.

Qualified Medical Child Support Orders. If you are eligible for coverage under the Plan, you may be required to provide coverage for your child pursuant to a Qualified Medical Child Support Order (QMCSO). A QMCSO is a judgment, decree or order issued by a state court or agency that creates or recognizes the existence of an eligible child's right to receive health care coverage. The Order must comply with applicable law and must be approved and accepted as a QMCSO by the Plan Administrator in accordance with Plan procedures.

If you divorce, you must provide the Fund Office with:

- **A copy of your divorce decree; and**
- **If you have children for whom you do not have custody, a copy of any QMCSO.**

If You Enter the Uniformed Services

The Fund complies with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). This legislation guarantees certain rights to individuals called to active duty in the armed forces of the United States.

If you are on active duty for 31 days or less, you will continue to receive health care coverage (medical, dental, prescription drug and optical benefits) provided under the Plan for up to 31 days.

If you are on active duty for more than 31 days, you can continue coverage for you and your dependents at your own expense for up to 24 months. In addition, your dependents may be eligible for health care coverage under TRICARE. This Plan will coordinate coverage with TRICARE. You must report your military leave to your employer in order to maintain eligibility. Under USERRA an active employee is required to notify the employer (in writing or orally) that he or she is leaving for military service unless circumstances or military necessity make notification impossible or unreasonable. Your employer is required to notify the Plan within 30 days after you are reemployed following military service; however, it is a good idea for you to notify the Fund Office, too.

Returning to work following discharge. When you return to work after receiving an honorable discharge, your full eligibility will be reinstated on the day you return to work with a contributing employer, provided that you return to employment within one of the following time frames:

- 90 days of the date of discharge if the period of military service is more than 180 days;
- 14 days from the date of discharge if the period of military service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury resulting from active duty, these time limits may be extended for up to two years. Contact the Fund Office for more details.

Coverage for Your Family After Your Death

If a covered member dies, his or her spouse and/or dependent children can continue coverage for 36 months. If you are an active participant and eligible for

coverage on the date of your death, your beneficiary will receive a death benefit (and an AD&D insurance benefit, if your death is accidental). See pages 41 and 42 for more information about the death and AD&D benefits.

Your surviving dependents may be eligible for COBRA continuation coverage following your death and after other Plan coverage ends (i.e., at the end of the three-year coverage period, if surviving dependents are not Medicare eligible).

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

- **Notify the Fund Office;**
- **Provide the Fund Office with a copy of your death certificate; and**
- **Apply for the death benefit (and AD&D insurance, if applicable).**

Eligibility for Pensioners

If you retire at age 62 with active medical benefits, then you and your dependents will be eligible for medical coverage with a Major Medical lifetime maximum of $50,000 per person. Dental and optical coverage will end for you and your dependents when your active benefits expire. You will be eligible for a $7,500 Death Benefit. Prescription drug benefits will continue but are subject to the maximums described in the Prescription Drug section (as summarized on the next page).

If you retire at age 65 or when you reach age 65 as a pensioner (or for any dependents you have as a pensioner who are age 65 and/or otherwise Medicare eligible), you (and any Medicare-eligible dependents) will be eligible for the Plan's Medicare Supplemental Benefits. Under this benefit, the Plan WILL NOT duplicate hospital and medical benefits available under Medicare for pensioners and dependents who are eligible for Medicare. It is important that all persons, in addition to enrolling in Medicare Part A (hospital benefits), enroll in Medicare Part B (doctor and medical benefits) as soon as they become eligible to do so and pay the applicable premium. Please note that, different from Parts A and B, the Plan does not coordinate with Part D (Medicare Prescription Drug coverage). If you enroll in a Medicare Part D Prescription Drug plan, you will lose your prescription drug benefits under the Local 14-14B Plan. (Note: only the individual enrolling in Medicare Part D will lose coverage under this Plan.)

If a pensioner's spouse is not eligible for Medicare when the pensioner is, regular retiree coverage will continue for the spouse until he/she becomes Medicare eligible. Then the spouse will receive the Fund's Medicare supplemental benefits. If the spouse is Medicare eligible and the pensioner is not Medicare eligible, the spouse will receive the Fund's Medicare supplemental benefits while the pensioner remains covered under the Fund's regular (retiree) coverage until he/she becomes Medicare eligible.

Medicare supplemental benefits. The Plan will supplement Medicare coverage to the extent described as follows:

- **Supplemental Medicare Part A (Hospital) Coverage.** You will receive the level of hospital benefits after Medicare pays its benefits, as outlined by your Hospital Certificate of Coverage. Please refer to the "Coordination of Benefits—Medicare" section for more details.
- **Supplemental Medicare Part B (Physician and Medical Benefits) Coverage.** The Plan will pay the deductible not covered by Medicare. The Plan will also pay the 20% coinsurance charge (the difference between what Medicare approves and pays) not covered by Medicare, provided that such charges do not exceed the Local 14-14B Welfare Fund's scheduled allowance for the particular service(s) rendered to the patient, but only up to the amount approved by Medicare. Please refer to the "Coordination of Benefits—Medicare" section for more details. It is important to note that if you do **not** enroll in Medicare Part B, there is no coverage under the Local 14-14B Welfare Fund.

- **Prescription Drug Benefits.** The Plan will pay prescription drug benefits but only up to the Plan maximum of $2,000 per person per calendar year for retail pharmacy and $1,500 per person per calendar year for mail order. If you or your spouse enroll in Medicare Part D, your (or your spouse's) prescription drug coverage under the Local 14-14B Plan will end. Anyone enrolled in Medicare Part D will not be eligible to receive benefits for any prescription drug benefits under this Plan.
- **Death Benefit.** You will continue to be covered for a $7,500 death benefit provided by the Fund.

The Plan will not reimburse Medicare Part B (Physician and Medical) or Medicare Part D (Prescription Drug Benefit) premium payments.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended requires that most group health plans offer employees and their families the opportunity for a temporary extension of health care coverage at group rates in certain instances when coverage under the Plan would otherwise end (called "qualifying events"). Continued coverage under COBRA applies to the health care benefits described in this booklet (but not the death, AD&D or disability benefits).

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

Qualifying COBRA events. The chart below shows when you and your eligible dependents may qualify for continued coverage under COBRA, and how long your coverage may continue.

If You Lose Coverage Because of This Reason (a "qualifying event")	These People Would Be Eligible	For COBRA Coverage Up To
Your coverage terminates*	You and your covered spouse and children	18 months **
Your working hours are reduced	You and your covered spouse and children	18 months **
You die	Your covered spouse and children	36 months
You divorce or legally separate	Your covered spouse and children	36 months
Your dependent child no longer qualifies as an eligible dependent	Your child	36 months
You become entitled to Medicare	Your covered spouse and children	36 months

** For any reason other than gross misconduct.*

*** Continued coverage for up to 29 months from the date of the initial event may be available to those who, during the first 60 days of continuation coverage, become totally disabled within the meaning of Title II or Title XVI of the Social Security Act. This additional 11 months is available to members and enrolled dependents if notice of disability is provided within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of coverage will increase to 150% of the full cost of coverage. Additionally, coverage can be extended for eligible dependents to a maximum of 36 months in the event of death or Medicare entitlement of the member or divorce or legal separation.*

Adding a dependent after COBRA coverage begins. If you have a newborn child, adopt a child or have a child placed with you for adoption while continuation coverage under COBRA is in effect, you may add the child to your coverage. To add coverage for the child, notify the Fund Office within 30 days of the child's birth, adoption or placement for adoption. Legal proof of your relationship to the child must also be provided.

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

For example, if your coverage terminates, you and your covered dependents may be eligible for 18 months of continued coverage. During this 18-month period, if your dependent child ceases to be a dependent under the Plan (a second qualifying event), your child may be eligible for an additional period of continued coverage. The two periods combined may not exceed a total of 36 months from the date of your termination (the first qualifying event). You or your family must notify the Fund Office if such an event occurs, in order to avoid confusion as to your status.

When you or your beneficiary must notify the Fund Office. As a covered member or qualified beneficiary, you are responsible for providing the Fund Office with timely notice of certain events. These events include:

- The divorce or legal separation of a covered member from his or her spouse.
- A beneficiary ceasing to be covered under the Plan as a dependent child of a participant.
- The occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second qualifying event could include an employee's death, entitlement to Medicare, divorce or legal separation, or a child losing dependent status.
- When a qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If this determination is made at any time during the first 60 days of COBRA coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA coverage.
- When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

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

How to provide notice. Notice of any of the five situations listed must be provided in writing. There are two ways you may do this. First, you may use the Fund's "COBRA Notice Form for Covered Employees and Qualified Beneficiaries." You may get a copy of this form from the Fund Office. The alternative way for you to provide notice is to send a letter to the Fund that contains the following information: your name and address, the names and addresses of your dependents, along with the nature and date of the occurrence you are reporting to the Fund. Your notice should be sent to:

International Union of Operating Engineers
Local 14-14B Welfare Fund
141-57 Northern Boulevard
Flushing, NY 11354

When the notice must be sent. The following rules apply in determining the deadline for providing notice:

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

- If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than 60 days after the later of (1) the date of the disability determination by the Social Security Administration; or (2) the date on which the qualified beneficiary is informed through the furnishing of a summary plan description or initial COBRA notice of the responsibility to provide the notice and the procedures for providing this notice to the Fund. Regardless, the notice must be sent no later than the end of the first 18 months of continuation coverage.
- If you are providing notice of a Social Security Administration determination that you are no longer disabled, notice must be sent no later than 30 days after the later of (1) the date of the determination by the Social Security Administration that you are no longer disabled; or (2) the date on which the qualified beneficiary is informed through the furnishing of a summary plan description or initial COBRA notice of the responsibility to provide the notice and the procedures for providing this notice to the Fund.
- If the notice has not been received by the Fund by the end of the applicable period described above, you and/or your dependent will not be entitled to choose/extend COBRA Continuation Coverage.
- If you notify the Fund Office of a qualifying event and you are not entitled to COBRA coverage, the Fund Office will send you a written notice stating the reason you are not eligible for COBRA. The Fund Office will provide this notice within 14 days after its receipt of your notice of a qualifying event.

Keep the Fund Office Informed of Address Changes

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

Electing COBRA coverage. The Fund must notify you and/or your covered dependents of your right to COBRA coverage after it receives notice or becomes aware that a qualifying event has occurred. **You will have 60 days to respond if you want to continue coverage—measured from the date coverage would otherwise end or, if earlier, the date you receive the COBRA notice.**

Paying for COBRA coverage. You have to pay the full cost of continued coverage as calculated under COBRA plus a 2% administrative fee. If you are eligible for 29 months of continued coverage due to disability, the law permits the Fund to charge up to 150% of the full cost of the Plan during the 19th to 29th months of coverage. Your first payment must be made within 45 days after you elect to continue coverage and must include all payments that are due. You may contact the Fund Office to confirm the correct amount of your first payment. All subsequent payments will be due on the first day of each month for that month's coverage. You will be notified by the Fund Office if the amount of your monthly payment changes. In addition, if the benefits change for active members, your coverage will change as well.

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

- Coverage has continued for the maximum 18, 29 or 36-month period.
- The Plan terminates. If the coverage is replaced, you may be continued under the new coverage.
- You or your dependents fail to make the necessary payments on time.
- You or a covered dependent become covered under another group health plan that does not exclude coverage for pre-existing conditions or the pre-existing conditions exclusion does not apply.
- You or a covered dependent become entitled to benefits under Medicare.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Full details of COBRA continuation coverage will be furnished to you or your eligible dependents when the Fund Office receives notice that a qualifying event has occurred. It is important to contact the Fund Office as soon as possible after one of these events occurs.

If COBRA coverage is cut short for any of the reasons described above, the Fund will send you a written notice as soon as practicable following the determination that COBRA coverage will terminate. The notice will detail why COBRA coverage will terminate early, the date of the termination and your rights, if any, to alternative individual or group coverage.

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

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

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

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

For more information. If you have any questions concerning the information in this section or your rights to COBRA coverage, you should contact the Fund Office.

Continued Coverage Under New York State Law: If you are not entitled to continuation of coverage under COBRA (for example, your employment terminates due to gross misconduct), you may be entitled to continue your hospital coverage under New York State law. Contact the Fund Office to find out if you qualify for continued coverage under New York State law.

If You Lose Eligibility for Hospital Coverage. In the event you are no longer eligible for hospital coverage under this Plan, you may be able to purchase a direct payment contract from the hospital carrier. Contact the carrier or the Fund Office for more information.

Your Health Benefits

Your health benefits are divided into several parts as described below:

Hospital Benefits

The Plan covers in-patient services for 365 days of care per calendar year for medically necessary charges at all hospitals. Your hospital benefits also cover some out-patient services. A description of hospital benefits begins on page 16.

Medical Benefits—Out-of-Network Benefits

Under the Plan, you are free to choose any provider you wish to provide you with health care. The Medical portion of the Plan—Basic and Major Medical benefits—generally covers medically necessary benefits at 90% of the Fund's scheduled allowance after you have satisfied the deductible, as described in detail beginning on page 19. Certain Basic Benefits are not subject to the deductible and may be paid in full up to the Fund's scheduled allowance.

In-Network Benefits

The Plan has also contracted with an in-network provider to provide in-network benefits at a lower cost to you and your family. In-network providers have agreements to provide health care services and supplies for a favorable negotiated fee applicable only to Plan participants. There are no copayments when you and/or your dependents use the services of an in-network provider.

About the network. Members have access to a network of medical providers at over 78,000 provider locations. In addition, ancillary services, laboratory and radiological services, free-standing out-patient facilities credentialed by the hospital carrier, durable medical equipment and home care are available.

Directory of Network Providers. Physicians and other providers who participate in the Plan's network are added or deleted during the year. At any time you can find out if any provider is a member of the network by contacting the Fund Office or by calling the telephone number on your ID card. Updated provider lists are available from the Fund Office free of charge.

Alcohol and Substance Abuse Benefits

The Plan covers benefits for alcohol and substance abuse treatment for up to 60 outpatient days, 7 detoxification in-patient and 30 in-patient days (once per lifetime) up to the maximums described on page 28.

Prescription Drug Benefits

The Plan also provides benefits for prescription drugs through Express Scripts for retail and mail order drugs as described on page 29.

Remember—always show:

- **your hospital ID card to the hospital or participating pharmacy.**
- **your Network Access Card to all other providers.**

How Your Hospital Benefits Work

Hospital Benefits

You are covered for hospital benefits as outlined in this section. Please note that this is a summary of the benefits as described in detail in your Certificate of Coverage which is evidence of the Group contract between the hospital carrier and the Local 14-14B Welfare Plan. If there is a discrepancy between this document and the Certificate, the rules of the Certificate will govern. You are covered only for the services listed in this booklet. The hospital carrier does not cover services unless they meet the following conditions:

a. The services must meet generally accepted standards of medical or hospital practice.

b. The services must not be in excess of the normally required treatment.

c. The services must be medically necessary. In making a determination regarding medical necessity, the hospital carrier will examine your treatment and your condition, the reasons for providing or prescribing the care and any unusual circumstances. However, the fact that your doctor prescribed the care does not automatically mean that the care qualifies for payment under this Plan.

The hospital carrier may require a provider's statement detailing the nature and necessity of a rendered service. This statement must be provided, if requested, in a form acceptable to the hospital carrier in order for you to receive benefits.

How to Obtain Hospital Benefits. Your Hospital Service Identification Card must be shown upon admission to a participating hospital. The hospital will contact the carrier to check eligibility and coverage. In the event you receive a bill after the hospital carrier has processed the claim, contact the Fund Office for assistance.

In-Patient Services

Criteria for In-Hospital Coverage. To qualify for benefits, you must meet all of the following conditions:

a. Be a registered bed patient in a hospital.

b. Need to stay in the hospital for the proper care and treatment of the illness or injury.

c. Be under the care of a physician.

"Hospital" is defined as a general hospital that has medical and surgical facilities for the care and treatment of the sick. It must provide 24-hour nursing service by registered graduate nurses who are present and on duty, and the hospital must be supervised by a staff of physicians.

Hospital services. Your benefits include all registered in-patient care customarily provided by the hospital, payable at 100%. The hospital carrier will pay only for a semi-private room or ward unless private accommodation is medically necessary to provide intensive care or other special care. A semi-private room is a room which the hospital considers to be semi-private. If you choose to occupy a private room, you will have to pay the difference between the semi-private and private room charges.

Number of Days of Care Covered. You are covered for the first 365 days of care in each "single hospital confinement." A "single hospital confinement" begins when you enter a hospital (as defined previously). Successive stays in one or more hospitals count as a single hospital confinement, unless 90 days or more elapse between the day of discharge and the next admission. Different limitations apply for hospitalization for psychiatric care.

The hospital carrier will pay for consecutive days of care from the date of your admission to the hospital. You cannot choose which days of care in a hospital you want us to pay for.

Special limitation on number of days of care covered for psychiatric care. You are covered for 30 days of care in a calendar year for your confinement in connection with mental, nervous, or emotional disorders. The confinement must take place in a hospital which meets the criteria described previously. These 30 days are not in addition to the 365 days of care in a "single hospital confinement." They are counted toward determining when you have reached the maximum 365 days.

Out-Patient Services

The hospital carrier covers out-patient services the same as in-patient services as follows:

- **Emergency care for an accident or injury.** The emergency care must be given within 72 hours of the accident or injury.
- **Emergency care for the sudden onset of an illness.** The emergency care must be given within 12 hours of the sudden onset of an illness which requires immediate care.

Emergency care is defined as care for a sudden, unexpected onset of a medical condition of such nature that failure to render immediate care could reasonably result in a deterioration to the point of placing the patient's life in jeopardy or causing serious impairment to the bodily function of the patient.

- **Care in connection with surgery.**
- **Pre-admission testing.** You are covered for tests ordered by a doctor which are given to you prior to your admission to the hospital as a registered in-patient for surgery. The tests must meet all of the following conditions:

  a. They must be performed at the same hospital where the procedure is scheduled to be done.

  b. They must be necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed.

  c. You must have a reservation for the hospital bed and for the operating room before the tests are given.

  d. You must be physically present at the hospital when the tests are given.

  e. Surgery must actually take place within 7 days after the tests are performed.

If surgery is cancelled because of these pre-surgical test findings, the carrier will still cover the cost of these tests.

- **Dialysis.** If you have chronic kidney failure and need hemodialysis or peritoneal dialysis, the hospital carrier will cover these services on an ambulatory or home basis to the following extent:

  a. In a hospital-based or free-standing facility, dialysis treatment on a walk-in basis is covered only if the dialysis program is approved by the appropriate governmental authorities.

  b. Home treatment is covered. The hospital carrier will cover the reasonable rental costs of equipment as they so determine, plus all appropriate and necessary supplies required for home dialysis treatment when ordered by the covered member's physician. Coverage will not include any furniture, electrical or other fixtures, plumbing, or professional assistance needed to perform the dialysis treatments at home.

  c. For home and facility-based benefits to be covered, the treatments must be provided, supervised, or arranged by a physician and you must be a registered patient of an approved kidney disease treatment center.

  d. Benefits for ambulatory and home dialysis are not subject to a time limit. The benefits continue while enrollment is in good standing or until you become eligible for coverage by Medicare.

Home Care Services

The hospital carrier will pay for home care visits made by a Certified Home Care Agency which has an Operating Certificate to provide home care issued under Article 36 of the New York State Public Health Law. Payment will not be made for care rendered by a **licensed** home care agency **unless** the home care agency has an Operating Certificate under Article 36.

The hospital carrier will pay for home care visits only if the following conditions are met:

- If you had not received home care visits, you would had to have been hospitalized or cared for in a skilled nursing facility. The home care visits must be a substitution for hospital care or care in a skilled nursing facility.
- A plan for your home care must have been established and approved in writing by a physician.

The following home care services provided by a home care agency or hospital are covered:

a. Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.).

b. Part-time or intermittent home health aide services which consist primarily of caring for the patient.

c. Physical, occupational, or speech therapy if the home care agency or hospital provides these services.

d. Medical supplies, drugs, and medications prescribed by a doctor, but only if the carrier would have paid for these items if you were in a hospital.

e. Laboratory services provided by or on behalf of the home care agency or hospital.

The hospital carrier will pay for home care visits and for the other services listed only for as long as you would otherwise have had to be confined in a hospital or confined in a skilled nursing facility. However, the carrier will not pay for more than 40 visits in each calendar year. Each visit by a member of a home care team is counted as one home care visit. Up to four hours of home health aide service are counted as one home care visit.

Exclusions

This contract does not cover the following hospital services:

a. Private-duty nursing services.

b. Special braces, appliances or equipment which only you can use.

c. Non-medical items, such as television rental.

d. Medications, supplies and equipment which you take home from the hospital.

e. Doctor's charges unless the doctor is employed by the hospital.

f. Ambulances and ambulettes.

g. Facility charges related to a separate surgical suite in a physician's office.

h. Clinic charges.

How Your Medical Benefits Work

Your medical benefits provide coverage for diagnosis and treatment of non-occupational illnesses and injuries, as well as certain preventive care. The Fund has entered into an arrangement with a panel of in-network providers, which is commonly referred to as a Preferred Provider Organization (PPO). The PPO contracts with physicians and other health care providers to provide you and your dependents with medical services at discounted rates.

In-Network Benefits

If you use an in-network provider, you simply show your hospital ID card and your expenses will be covered in full for services allowable under the Plan. Your participating provider will be paid directly by the Local 14-14B Welfare Fund. There are no out-of-pocket expenses if you use in-network providers.

Out-of-Network Benefits

Out-of-network expenses are subject to the Major Medical deductible – the amount you must pay before the Plan starts to pay benefits. This deductible is $100 for eligible out-of-network expenses and applies only once every calendar year. Eligible expenses do not include amounts paid under the Plan's Basic Benefits. It will be necessary for you to submit satisfactory proof of each charge used to satisfy the deductible.

When the $100 deductible has been satisfied in a calendar year by any two covered persons within a family unit (including the member), no further deductible will be applied during the remainder of that calendar year to eligible expenses of other covered family members that are incurred on or after the date the second deductible is met.

Emergency room doctor charges are not subject to the deductible. They will be paid at 90% of the Fund's Scheduled Allowance.

Carryover Deductible: Any eligible expenses incurred during the last three months of the previous year that were applied to that year's deductible (whether or not the full deductible was satisfied for the previous year) may be carried over and also applied to the deductible in the new year. As a result, Major Medical benefits will be payable earlier in the new year when the carryover deductible provision is applied.

Common Accident Deductible: If any two covered family members are injured in the same accident, all eligible expenses due to the accident will be combined and only one yearly deductible will be applied to such expenses.

After the Plan pays 90% of the allowed amount for out-of-network expenses, you will be responsible for the other 10% (this amount is called your coinsurance), plus all charges above the allowed amount.

Out-of-network expenses generally are subject to yearly deductibles and maximum limits and reimbursed at 90% of the Fund's scheduled allowance. Only out-of-network Major Medical expenses count toward the $2,000 per calendar year out-of-pocket limit. Deductible amounts are not counted toward the out-of-pocket maximum. Basic Benefits are not subject to the deductible as indicated on the Summary of Benefits.

Benefit Maximums

The Plan has a $200,000 per person lifetime Major Medical benefit maximum for active employees and their dependents (for in- and out-of-network benefits). The per-person lifetime medical benefit maximum for pensioners is $25,000. There are also limits on how much (and how often) the Plan will pay for certain expenses, even when they're covered. If there are limits on a particular expense, it will be detailed where a covered service is explained.

Summary of Benefits

Provision	In-Network	Major Medical (Out-of-Network)
How You Access Care	Go to any network provider.	Go to any licensed/certified non-participatory provider.
Basis for Reimbursement	All in-network reimbursements are based on the **allowed amount** for **medically necessary eligible expenses.** Network providers have agreed to accept the allowed amount as **payment in full.**	Out-of-network reimbursements are based on the **allowed amount** for **medically necessary eligible expenses** and subject to **coinsurance** after the deductible. Some basic benefits are not subject to the $100/$200 deductible.
Deductible	Not applicable	$100 per individual/$200 per family
Coinsurance (where applicable)	Plan pays 100%	Plan pays 90% of the Fund's scheduled allowance.
Annual Coinsurance Maximum	Not applicable	$2,000
Hospital Benefits – See applicable section beginning on page 16		
Medical Care		
General Medical and Preventive Care (including home and office visits and adult annual exams and immunizations)	Plan pays 100%	Plan pays 90% of the Fund's scheduled allowance after deductible.
Emergency Room Doctor Charges	Plan pays 100%	Plan pays 90% of the Fund's scheduled allowance.
Well Child Care (to the end of the year in which he or she turns either age 19 or age 25 if a full-time student) ■ Routine physical examinations ■ Vision screenings (no refractions) ■ Hearing screenings ■ Developmental assessment, anticipatory guidance and laboratory tests ordered ■ Immunizations and boosters	The Plan covers well child care visits at the following intervals: To age 1 – 5 visits Age 1 to age 2 – 3 visits Age 2 to age 3 – 2 visits Age 3 to age 19 – 1 visit every 12 months Age 19 to age 25 (if full-time, dependent students) – 1 visit every 12 months	
	Plan pays 100%	Plan pays 90% of the Fund's scheduled allowance. Immunizations: Plan pays up to 90% of the Fund's scheduled allowance.
Mammography/Pap Smear	Plan pays 100%	Plan pays 100% of the Fund's scheduled allowance.
Surgery	Plan pays 100%	Plan pays 100% of the Fund's scheduled allowance. Assistant Surgeon: Plan pays up to 25% of the Fund's scheduled allowance.

Summary of Benefits *continued*

Provision	In-Network	Major Medical (Out-of-Network)
Obstetrical Care	Plan pays 100%	Plan pays up to 100% of the Fund's scheduled allowance.
Diagnostic X-rays and Lab Tests (including PSA and Bone Density Tests)	Plan pays 100%	Screening: Plan pays 100% of the Fund's scheduled allowance. Interpretation: Plan pays up to 50% of the Fund's scheduled allowance.
Chiropractic Care (member and spouse only)	Plan pays 100%, up to 40 visits per year.	Plan pays 100% of the Fund's scheduled allowance, up to 40 visits per year.
Out-Patient Mental Health Services	Plan pays 100%, up to 50 visits per calendar year (in-network and out-of-network visits combined).	Plan pays 90% of the Fund's scheduled allowance, up to 50 visits per calendar year (in-network and out-of-network visits combined).
Diabetes Self-Management and Education	Plan pays 100%	Unlimited visits to a dietician with a doctor's prescription. Diabetes education from a certified nutritionist covered at 90% of the Fund's scheduled allowance.
Infertility Treatment	Plan pays 100%, up to $5,000 lifetime maximum per couple.	Plan pays 90% of the Fund's scheduled allowance, up to $5,000 lifetime maximum per couple (combined with in-network benefits).
Contraceptive Devices (such as intra-uterine devices (IUDs))	Plan pays 100%	Plan pays 90% of the Fund's scheduled allowance.
Local Ambulance Service	Not applicable	Plan pays 90% of the Fund's scheduled allowance.
Reconstructive and corrective surgery, only when it is: ■ Performed to correct the congenital birth defect of a dependent child, which resulted in a functional defect. ■ Incidental to surgery, or following surgery necessitated by trauma, infection, or disease of the involved part. ■ Breast reconstruction or implanted breast prostheses, following a mastectomy.	Plan pays 100%	Plan pays 100% of the Fund's scheduled allowance.

Summary of Benefits *continued*

Provision	In-Network	Major Medical (Out-of-Network)
Durable Medical Equipment and Supplies and Non-Durable Supplies (Contact the Fund Office for a list of covered expenses.)	Plan pays 100%	Plan pays 90% of the Fund's scheduled allowance.
Nursing Care		
■ In-hospital	Not applicable	■ Plan pays 90% of the Fund's scheduled allowance.
■ Out-of-hospital (for acute illnesses only)	Not applicable	■ Plan pays 90% of the Fund's scheduled allowance if prior authorization is obtained from the Fund's Medical Advisor; subject to a maximum lifetime benefit of $5,000 per person.
■ Home Care (through the hospital carrier—see page 18)		
Occupational Therapy	Plan pays 100%	Generally limited to 24 sessions in a three-month period. Plan pays 90% of the Fund's scheduled allowance.
Physiotherapy	Plan pays 100%	Plan pays 90% of the Fund's scheduled allowance.
Podiatry	Plan pays 100%	Plan pays 90% of the Fund's scheduled allowance.
Physical Therapy	Plan pays 100%	Generally limited to 24 sessions in a three-month period. Plan pays 90% of the Fund's scheduled allowance.
	Physical therapy by a podiatrist is limited to 12 sessions per illness (the Fund's Medical Advisor may approve additional sessions).	
Cardiovascular Physical Therapy	Plan pays 100%	Plan pays 90% of the Fund's scheduled allowance.
	Limited to a $2,000 lifetime maximum benefit; must be performed under a doctor's supervision.	
Acupuncture Therapy (must be performed by a Medical Doctor)	Not applicable	Limited to 12 sessions per year; additional sessions must be medically necessary, approved by the Fund's Medical Advisor and performed by an M.D. Plan pays 90% of the Fund's scheduled allowance.
Flu Shots	Plan pays 100%	Plan pays 90% of the Fund's scheduled allowance.
Lyme Disease Vaccination	Plan pays 100%	Plan pays 90% of the Fund's scheduled allowance.
Alcohol and Substance Abuse Treatment Services	See applicable section beginning on page 28.	

Determining What is Medically Necessary

Medically Necessary means services, supplies or equipment that are all of the following:

- Provided by a hospital (other than a hospital clinic) or other provider of health services;
- Consistent with the symptoms or diagnosis and treatment of the patient's condition, illness or injury;
- Meet the standards of good medical practice;
- Not solely for the convenience of the patient, the family or the provider;
- Not primarily custodial; and
- The most appropriate level and type of service that can be safely provided to the patient.

The fact that a network provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it medically necessary.

The amount payable for covered expenses will be based on the Fund's schedule of allowances. The Plan will not always pay benefits equal to or based on the physician's actual charge for health care services or supplies, even after you have paid the applicable deductible. This is because the Plan covers only up to the Fund's schedule of allowances for health care services or supplies.

The allowance payable by this Plan is set by the Trustees at a prescribed level and this level may be adjusted from time to time by the Trustees in their sole and absolute discretion. The maximum allowance for in-network providers is determined according to the negotiated rate between the carrier and the provider. The schedule of allowances is maintained by the Fund Office and the amount allowable by the Fund for specific services or procedures is available upon request.

What's Not Covered Under Your Major Medical Benefits

The following is a list of exclusions of medical services, supplies or expenses not covered under your Major Medical benefits. Refer to the the hospital carrier's Certificate of Coverage for hospital coverage exclusions and limitations.

- **Educational services:** Expenses for educational services, supplies or equipment, including, but not limited to, computers, software, printers, books, tutoring, visual aids, auditory aids, speech aids, etc., even if they are required because of an injury, illness or disability of a covered person.
- **Expenses exceeding maximum plan benefits:** Expenses that exceed any Plan benefit limitation, annual maximum Plan benefit, or lifetime maximum Plan benefit, except as provided by the automatic restoration provision as described in this document.
- **Expenses for which a third party is responsible:** Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party. See the section entitled "Subrogation" in this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
- **Expenses incurred before or after coverage:** Expenses for services rendered or supplies provided before the patient became covered under the Plan, or after the date the patient's coverage ends.
- **Modifications of homes or vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a covered person, including, without limitation, construction or modification of ramps, elevators, chair lifts, swimming pools, spas, air conditioning, etc.
- **Dental services** except expenses for necessary services for correction of damage caused by accidental injury while insured.
- **Loss incurred** while engaged in military, naval or air service, except as required by USERRA.
- **Home nursing care** for chronic illness.
- **Any loss,** or portion thereof, for which mandatory automobile no-fault benefits are recovered or recoverable.
- **No prescription:** Expenses for services rendered or supplies provided that are not recommended or prescribed by a doctor or covered health care practitioner.
- **Non-emergency travel and related expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a health care practitioner, covered person or a family member of the covered person.
- **Occupational illness, injury or conditions subject to workers' compensation:** All expenses incurred by a covered person arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. This applies even if the covered person was not covered by workers' compensation insurance, or if the covered person's rights under workers' compensation or occupational disease or similar law has been waived or qualified. The Plan will pay benefits if the workers' compensation claim is contested, denied or subject to the subrogation, repayment, and lien provisions described in the Subrogation section of this booklet.
- **Personal comfort items:** Expenses for patient convenience, including, but not limited to, care of family members while the covered person is confined to a hospital or other specialized health care facility or to bed at home; guest meals; television; VCR; telephone; barber or beautician services; house cleaning or maintenance; shopping; birth announcements; photographs of new babies; etc.
- **Clinic charges.**

- **Physical examinations, tests for employment, school, etc.:** Expenses for physical examinations testing and immunizations required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports or by any third party.
- **Relatives providing services:** Expenses for services provided by any doctor or other health care practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or member.
- **Spouses** who are otherwise eligible for this Fund's coverage and who waive or receive an incentive to opt-out of employer-provided or other Fund group health benefits (except COBRA) will not receive benefits from this Plan. See the "Coordination of Benefits" section in this booklet for more information.
- **Stand-by doctors or health care practitioners:** Expenses for any doctor or other health care practitioner who did not directly provide or supervise medical services to the patient, even if the doctor or health care practitioner was available to do so on a stand-by basis.
- **Telephone calls:** Any and all telephone calls between a doctor or other health care practitioner and any patient, other health care provider, utilization management company, or any representative of the Plan for any purposes whatsoever.
- **War or similar event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion or invasion, except as required by law.
- **Expenses for acupressure.**
- **Expenses for chelation therapy,** except as may be medically necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due clearly to a demonstrated excess of copper or iron.
- **Expenses for prayer, religious healing or spiritual healing,** including services.
- **Expenses for naturopathic, naprapathic and/or homeopathic** services, substances or supplies.
- **Expenses for hypnosis, hypnotherapy and/or biofeedback.**
- **Expenses for counseling services related to:**
  - Adoption counseling
  - Court-ordered behavioral health care services
  - Custody counseling
  - Family planning counseling
  - Marriage, couples, and/or sex counseling
  - Transsexual counseling
  - Vocational disabilities.
- **Expenses for replacement of lost, missing, or stolen** corrective appliances, prosthetic appliances or durable medical equipment.
- **Expenses for duplicate** corrective appliances, prosthetic appliances or durable medical equipment.
- **Orthotics.**
- **Expenses for services or supplies designed to personalize or characterize** any corrective appliance, including orthotic devices and/or prosthetic appliances or durable medical equipment.
- **Expenses for corrective appliances** and durable medical equipment to the extent they exceed the cost of standard models of such appliances or equipment.
- **Cosmetic services exclusions:** Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. The Plan does cover reconstructive surgery and treatment related to injuries and illness (upon approval of the Fund's Medical Advisor) and breast reconstruction in connection with mastectomies.
- **Expenses for custodial care** regardless of where it is provided, including, without limitation, adult day care, child day care, services of a homemaker or personal care.

- **Foods and nutritional supplements** including, but not limited to, home meals, formulas, foods, diets, vitamins and minerals (whether they can be purchased over-the-counter or require a prescription), except when provided during hospitalization.
- **Take-home drugs** or medicine provided by a hospital, emergency room, ambulatory surgical center or other health care facility.
- Any **prescription drug or medicine not provided by the Plan's** prescription **drug card or mail order** drug programs.
- **Hearing aids.**
- **Hair replacement or removal procedures, medications and devices (wigs):** Expenses for hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair; for the use of Minoxidil, Propecia, Rogaine, or other prescription or nonprescription drugs, medicines or services used to promote the growth of hair; or for hair replacement devices including, but not limited to, wigs, toupees and/or hairpieces.
- **Emergency contraceptive pills; contraceptive devices** such as diaphragms; **implantable birth control devices,** such as Norplant; and condoms; **birth control surgical procedures,** such as vasectomies and tubal ligations and related pre-testing.
- **Abortions.**
- **Core blood harvesting/storage unless medically necessary.**
- **Home delivery:** Expenses for pre-planned home delivery.
- **Prophylactic surgery or treatment:** Expenses for all medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery **except when a family history and genetic confirmation of a disease or disorder exists AND upon the approval of the Plan's Medical Advisor.** Amniocentesis, chorionic villus sampling (CVS) and alphafetoprotein (AFP) analysis are covered.
- **Expenses for education, job training and/or vocational rehabilitation.**
- **Expenses for massage therapy, rolfing and related services.**
- **Expenses for speech therapy for functional purposes** including, but not limited to, stuttering, stammering and conditions of psychoneurotic origin.
- **Treatment of sexual dysfunctions not caused by a medical condition,** as determined by the Plan's Medical Advisor.
- **Sex change counseling, therapy and surgery:** Expenses for medical, surgical or prescription drug treatment related to transsexual (sex change) procedures, or in the preparation for such procedures, or any complications resulting from such procedures.
- **Smoking cessation or tobacco withdrawal products:** Expenses for products, services or programs intended to assist an individual to stop smoking, except for prescription items that are covered under your prescription drug benefits.
- **Expenses for surgical correction of refractive errors and refractive keratoplasty procedures** including, but not limited to, radial keratotomy (RK) and automated keratoplasty (ALK).
- **Expenses for diagnosis and treatment of refractive errors,** including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies **except as provided by the Plan's optical benefits.**
- **Vision therapy** and supplies, and **orthoptics.**
- **Expenses** for services provided by **certified registered nursing assistants, physician assistants and nurse practitioners.**
- **Expenses for medical or surgical treatment of obesity** that is **not pathologically defined** obesity.

- **Expenses for medical or surgical treatment of severe underweight,** including, but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25% under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by doctors to determine normal body weight.

- **Expenses for memberships in or visits to** health clubs, exercise programs, gymnasiums and/or any other facility for **physical fitness programs.**

- **Expenses for human organ and/or tissue that are experimental and/or investigational, including, but not limited to,** donor screening, acquisition and selection, organ or tissue all complications thereof. (Transplants that are medically justified/necessary are covered. Expenses incurred by the person who donates the organ or tissue is covered if approved by the Fund's Medical Advisor.)

- This Plan will not cover **any claim rejected by a primary plan that denies coverage because a dependent of a covered member did not comply with rules and regulations of such primary plan.** For example in the event that a primary plan requires the use of certain doctors as evidenced by participation and eligibility in a Health Maintenance Organization (HMO), or another approved health diagnosis or medical delivery center and one of those doctors is not used, this Plan as the secondary plan, will not cover any claim rejected by the primary plan.

- **Expenses** that are **not medically necessary, including expenses for experimental or investigational treatment.** See page 23 for definition of medically necessary.

- **Technology, including treatments, procedures, drugs, biologicals, or medical devices** that, in our sole discretion, are **not medically necessary** because they are:
  - **Experimental**
  - **Investigational**
  - **Obsolete**
  - **Ineffective**

No hospitalizations in connection with such technology will be covered. Any or all of the following five criteria may be applied in determining whether a technology is experimental or investigative, obsolete or ineffective:

1. The medical device, drug or biological product must have received the U.S. Food and Drug Administration's (FDA) final approval to be marketed for the particular diagnosis or condition. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or all of these five criteria shall be met.

2. Conclusive evidence (from the published peer-reviewed medical literature) must exist that the technology has a definite positive effect on health outcomes.

3. Demonstrated evidence (as reflected in the published peer-reviewed medical literature) that over time the technology leads to improvement in health outcomes (that is, beneficial effects outweigh any harmful effects).

4. Proof (as reflected in the published peer-reviewed medical literature) must exist that the technology is at least effective in improving health outcomes, or is usable in appropriate clinical contexts in which established technology is not employable.

5. Proof (as reflected in the published peer-reviewed medical literature) must exist that improvement in health outcomes (as defined in #3 above) is possible in standard conditions of medical practice, outside clinical investigatory settings.

- **Expenses that exceed the scheduled allowance.** The charge for medically necessary services or supplies will be determined by the Plan Trustees or their designee. Contact the Fund Office or check with the hospital carrier for more information.

Alcohol and Substance Abuse Coverage

Member Assistance Program

The Plan provides alcohol and substance abuse coverage for you and your dependents. The Member Assistance Program can refer you to an alcohol or substance abuse treatment facility.

For alcohol or substance abuse treatment facility recommendations and related information, call the Fund Office.

Out-Patient Alcohol and Substance Abuse Services (Paid by the Hospital Carrier)

The Plan covers up to 60 out-patient visits per calendar year at certified alcohol and substance abuse facilities and/or one in-patient stay for detoxification, up to seven days, paying 100% of the cost with no deductible. If you have family coverage, up to 20 of the 60 visits available to the person with the alcohol or substance abuse problem may be used for family therapy. Contact the hospital carrier or the Fund Office for a copy of the Certificate of Coverage.

Only one visit per day is covered, except two visits in the same day will be covered if one is for family therapy and the other separate visit is for the person with the alcohol or substance abuse problem.

In-Patient Alcohol and Substance Abuse Services (Covered by the Local 14-14B Welfare Fund)

Your lifetime maximum benefit includes one in-patient stay for rehabilitation, up to a maximum 30 days, and subject to a $100 deductible. A lifetime maximum benefit of $7,000 also applies to in-patient stays. These in-patient benefits are paid at 90% of the Fund's scheduled allowance.

The Plan covers in-patient stays at any specialized and certified substance abuse facility, including Veritas Villa and the Seafield Center. It also covers emergency room charges for psychotic and psychiatric patients at the same level as regular emergency room care.

Your Prescription Drug Benefits

At the Pharmacy

The prescription ID card is the same as your hospital ID card and identifies you and your covered dependents. You and your covered dependents must present your hospital ID card to the pharmacist at a participating network pharmacy, together with the prescription. You then pay the appropriate copayment for each prescription, either $10 for a brand name drug or $5 for a generic drug.

Your copayment for brand name drugs is $10.
Your copayment for generic drugs is $5.

If you fail to show your hospital ID card at a network pharmacy, you must pay the pharmacy in full and then file a claim with Express Scripts for reimbursement. You will then be responsible for either the $10 brand name or $5 generic drug copayment.

Through the Mail Order Prescription Program

If you and/or your covered dependents need prescription medication on a regular or long-term basis, or more than a 34-day supply, you may order up to a 90-day supply of medication (plus refills) through the mail order program. You will receive your medication within 14 days.

Call Express Scripts at 1-877-534-3682 or log onto the website at www.express-scripts.com to order mail order forms or to ask questions about the mail order program. When you receive the forms, you must also complete the mail service envelope and patient profile questionnaire and mail it with your prescription to the mail service pharmacy.

The Mail Order program saves money for both you and the Fund.

Original Prescriptions

Ask your doctor for a written prescription for up to a 90-day supply of medication (plus refills). The written prescription must include the following:

- Patient's full name and address;
- Prescribing doctor's name; and
- Quantity, strength and dosage of drug.

Refills. When ordering refills, place your order at least three weeks before the time your current supply will run out. If you call the Express Scripts mail order program at 1-877-534-3682 to order a refill, be ready to give the following information:

- The member's or pensioner's Social Security number; the member's ID number listed on the card.
- The prescription number (located in the box on the prescription and refill labels); and
- Your daytime phone number and area code.

Annual Maximum Benefit

Benefits for prescription drugs at the retail pharmacy are subject to a $750 annual maximum benefit per active member family. There is no annual maximum for mail order prescriptions.

Pensioners and their covered dependents can each receive up to $2,000 in retail drug benefits each calendar year. The maximum benefit for drugs received through the mail order program is $1,500 per individual each calendar year.

If you are a Medicare-eligible retiree or the Medicare-eligible dependent of a retiree, you will continue to receive prescription benefits from the Plan only if you do NOT enroll in a Medicare prescription drug plan, known as Part D plans. If you enroll in a Medicare prescription drug plan, you will lose prescription drug benefits under this Plan. If you enroll in a Medicare Part D plan and lose prescription drug coverage under this Plan, you cannot re-enroll in this Plan's prescription drug coverage in the future.

Summary of Prescription Drug Benefits

Service	Benefit
Copayment for Brand Name Drugs	$10 retail/$0 mail order
Copayment for Generic Drugs	$5 retail/$0 mail order
Retail Pharmacy Supply	34 days per prescription or refill
Mail Order Maintenance Supply	90 days per prescription or refill
Plan Maximum—Active Members and Dependents	Retail pharmacy: $750 per person per calendar year Mail order: no maximum
Plan Maximum—Pensioners	Retail pharmacy: $2,000 per person per calendar year Mail order: $1,500 per person per calendar year

If you retire with active medical benefits, you have no maximum on mail order drugs until the active benefits expire. At that point, you have a $1,500 maximum mail order benefit for the remainder of the year and thereafter.

Eligible Drugs

Only prescription drugs purchased at network pharmacies or through the mail order program are covered.

Prescription drugs dispensed at non-participating pharmacies are not covered.

The program covers drugs that are doctor prescribed and approved by the Food and Drug Administration (FDA). Covered drugs and items include: prescription contraceptives (birth control pills), needles and syringes and insulin and diabetic supplies.

See the Ineligible Drugs section for a list of the drug program's limitations and exclusions.

Ineligible Drugs (Limits and Exclusions)

Your prescription drug benefits do **not** cover the following:

- Prescription drugs dispensed at a non-participating pharmacy.
- Drugs which by law do not require a prescription or are available over-the-counter, **except** insulin and self-administered injectables.
- Devices of any type (e.g., therapeutic devices, artificial appliances, or similar devices), except where specifically covered.
- Vitamins which by law do not require a prescription.
- Investigational or experimental drugs (i.e., medications used for experimental indications and/or dosage regimens determined as experimental, including drugs labeled "Caution-limited by Federal Law to Investigational Use") even though a charge is made to an individual.
- Compounded medications with no ingredients requiring a prescription order.
- Medications for cosmetic purposes only.
- Medications with no approved FDA indications, unless otherwise required by law (i.e., drugs that have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA).
- Replacement prescription medications resulting from loss, theft or breakage.

- The cost of medicine dispensed in excess of the contractual limitation.
- Drugs to treat infertility.
- Non-Federal legend (FDA-approved) drugs.
- Over-the-counter contraceptive jellies, creams, foams, devices or implants.
- Mifeprex (abortion drug).
- The amount of drug which is to be dispensed per prescription or refill will be in quantities prescribed up to a 34-day supply.
- A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine, Propecia) or for cosmetic purposes only (e.g., Renova, Vaniqa®).
- Medication for which the cost is recoverable under any workers' compensation or Occupational Disease Law or any state or governmental agency or medication furnished by any other drug or medical service for which no charge is made to the individual.
- Medication which is to be taken or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.

The Board of Trustees will review this list from time to time in light of new drugs approved by the FDA and other considerations and will revise the list of covered and non-covered drugs based on criteria established by Express Scripts. Please contact Express Scripts for the most up-to-date information on drugs not covered by the Plan.

Your Dental Benefits

The Local 14-14B Welfare Fund offers dental benefits, excluding orthodontia, to active members and their covered dependents through Delta Dental. You have the option of choosing a participating dentist from either the DeltaPreferred or DeltaPremier networks.

Orthodontia services for covered dependent children of active members are provided and paid for by the Local 14-14B Welfare Fund, not through Delta Dental.

The two Delta Dental networks differ in size and cost. DeltaPremier has the largest dental network and pays a higher amount per procedure. DeltaPreferred has a smaller dental network and their dentists agree to accept less per procedure. *For purposes of this Plan, DeltaPreferred's network dentists are defined as in-network providers; DeltaPremier's network dentists and non-participating dentists are defined as out-of-network providers.*

The following sections describe how the Delta Dental Plan operates. It also describes the orthodontic benefits paid for by the Fund. If you have any questions, be sure to call the Fund Office or the insurance provider.

How Your Dental Plan Works

The Plan is designed to help you pay for reasonably necessary dental care and is available to members and their dependents (spouses and dependent children to age 19; 25 if full-time student). Read this section carefully to fully understand which expenses are covered, and how they are covered, keeping in mind that, as a rule, the Plan covers only those services that are considered essential to good dental health. A list of covered dental expenses starts on page 34.

How Eligible Dental Expenses Are Defined

To be considered for an eligible dental expense, a dental service must meet the following criteria:

- It must be provided or performed by a dentist (or, for some treatments such as teeth cleaning, by a licensed dental hygienist working under the dentist's supervision).
- It must be for reasonably necessary dental care.
- It must be a covered expense.

Ineligible dental expenses not covered by the Plan are listed on page 35.

How to Use the Plan

The Local 14-14B Welfare Fund provides a DeltaPreferred Option dental program with a Point of Service option for members, members' spouses and their dependent children (to age 19 or age 25 if a full-time dependent student). The Dental Plan offers you the freedom to visit any dental care provider you would like and still receive benefits for covered services. However, if you take advantage of the DeltaPreferred network, your savings will be greater.

Using DeltaPreferred dentists. When you receive care from a DeltaPreferred dentist (an in-network provider), the Plan pays 100% of your eligible dental expenses with no deductible. All benefits are subject to Plan limits, as described in the following pages. For a directory of participating DeltaPreferred dentists in your area, go to www.midatlanticdeltadental.com or call 1-800-932-0783 or TTY/TDD 1-888-373-3582.

When you call to make an appointment with a participating dentist, please verify that your dentist accepts the Local 14-14B Welfare Fund fee schedule as payment in full. Otherwise, you may be responsible for paying part of the dentist's charges.

Using DeltaPremier and non-participating dentists. When you use DeltaPremier dentists, the dentists are paid directly by Delta Dental, and by agreement cannot bill the patient more than the applicable copayments or deductibles for the services provided.

When you use a non-participating dentist, you will need to pay the dentist in full at each visit, and then follow the dental claims procedure (see page 45). If a non-participating dentist charges you more than the allowed amount (see page 34), you must pay the difference. For example, if the allowed amount for a routine checkup is $22 but your dentist charges you $125, you'd be responsible for the $103 difference. Generally, it costs more out-of-pocket if you go to a DeltaPremier or non-participating dentist.

Maximum Benefits

The maximum benefit the Dental Plan will pay is $1,500/person or $4,500/family a calendar year (in- and out-of-network combined).

Summary of Dental Benefits

Provision	In-Network Coverage (DeltaPreferred)	Out-of-Network Coverage (DeltaPremier and Non-Participating Providers) (subject to deductible)
How You Access Care	Go to any PPO dentist who accepts the Local 14-14B Welfare Fund's fee schedule.	Go to any licensed/certified dentist in DeltaPremier network or a non-participating dentist.
Annual Deductible waived for diagnostic and preventive services	None	$50 per person $100 per family.
Annual Maximum Benefit	$1,500 per person or $4,500 per family per calendar year	
	Diagnostic, Preventive and Other Services	
Diagnostic Services (exam and x-ray)	100%	100% of allowance
Preventive Services (cleaning teeth, children and adult fluoride treatments to age 19 and sealants to age 14)	100%	100% of allowance
Basic Restorative (fillings)	50%	50% of allowance
Major Restorative (crowns)	50%	50% of allowance
Oral Surgery (extractions)	50%	50% of allowance
Endodontics (root canal therapy)	50%	50% of allowance
Periodontics (treatment of gum disorders)	50%	50% of allowance
Prosthodontics (dentures, bridgework)	50%	50% of allowance
TMJ (temporomandibular joint dysfunction treatment)	50%	50% of allowance

Benefits When Alternate Procedures Are Available

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results and are recognized by the profession as appropriate methods of treatment in accordance with broadly accepted national standards of dental practice. When alternate services or supplies can be used, the Plan will cover the least expensive services or supplies necessary to treat the condition. Of course, you and your dentist can still choose the more costly treatment method, in which case you would be responsible for any charges the Plan will not cover.

Predetermination

If the cost of care to be provided to any one patient is expected to exceed $300, Delta recommends that you ask your dentist to submit the claim form in advance of treatment. Delta will review the claim and return a predetermination to both you and the dentist indicating the services that are covered, how much of the proposed treatment will be paid by Delta and how much will be your responsibility. Predetermination makes it easier to plan an appropriate course of treatment and it helps you by providing an advance breakdown of the coverages and charges.

Orthodontia Benefits

Orthodontia services for covered dependents of active members only are provided and paid for by the Local 14-14B Welfare Fund and not through Delta Dental. The lifetime maximum benefit is $4,000 for each covered dependent child. Benefits under this Plan are limited to an active course of orthodontia treatment including diagnosis, evaluation, pre-care, initial installation of orthodontic appliances and adjustment of active orthodontia appliances. This orthodontia benefit is for non-surgical services provided to correct malocclusion (alignment of the teeth and/or jaws) and is paid when the dependent child is banded. Repair or replacement of orthodontia appliances is not covered. For more information, please contact the Fund Office.

What's Not Covered by the Delta Dental Plan

The following is a partial list of services not covered through the Delta Dental Plan:

- Services provided or devices started prior to the effective date of the Plan;
- Prescription drugs;
- Premedications;
- Relative analgesia;
- General anesthesia, except with oral surgery;
- Charges for hospitalization, including hospital visits;
- Plaque control programs, including oral hygiene and dietary instruction;
- Procedures to correct congenital or developmental malformations, **except** for children eligible at birth;
- Procedures, appliances or restorations primarily for cosmetic purposes;
- Increasing vertical dimension;
- Replacing tooth structure lost by attrition;
- Periodontal splinting;
- Gnathological recordings;
- Equilibration;
- Implants; and
- Orthodontic services, including tooth guidance appliances (The Fund pays for and administers orthodontia coverage; please see this page).

Contact the Fund Office for a full list of limitations and exclusions.

Your Optical Benefits

The Fund provides optical benefits through General Vision Services (GVS) and through Vision Screening. You and your dependents can receive certain optical benefits at no cost once every 24 months if you obtain services through GVS or its Member Offices or Vision Screening. GVS Member Offices are independent doctors who contract with GVS and Vision Screening to provide vision services to eligible Local 14-14B members and their dependents that reside outside the New York metropolitan area.

If you choose not to use either GVS or Vision Screening, you can still receive optical benefits. The Fund will reimburse eligible out-of-network expenses up to $250 every 24 months.

To obtain a voucher, a list of GVS offices and Vision Screening information, call the Fund Office. For GVS Member Office locations, call 1-800-VISION-1.

Eligible Optical Expenses Through GVS or Vision Screening

Once every 24 months, you and each covered dependent are entitled to the following optical expenses:

- A comprehensive eye examination including cataract and glaucoma screening.
- A complete pair of eyeglasses including frames from the GVS or Vision Screening collections, prescription plastic lenses (including single vision, bifocals, blended bifocals, trifocals, multifocals, hi-index (1.60), basic progressive, safety, oversize and cataract lenses), cosmetic tints, Rx sunglass tints, UV coating, scratch resistant and anti-reflective coatings.
- Standard soft daily wear and extended wear contact lenses (in lieu of glasses) or basic disposable contact lenses for 9 months (6 boxes) including fitting fee and unlimited follow-up exams for one year. (Colored contact lenses are not included.)

If you don't use a GVS or Vision Screening provider, the Fund will still pay up to $250 maximum for eligible optical expenses every 24 months.

Laser Vision Surgery

The Fund will pay your eligible expenses for laser vision surgery (sometimes referred to as Lasik), up to a lifetime maximum benefit of $500 per eye.

Ineligible Optical Expenses

The following optical products and services are ineligible expenses under the Plan:

- Expenses incurred for ophthalmic treatment or services payable under the provisions of any other benefit of the Plan.
- Non-prescription eyeglasses.
- Adornment expenses.

How to Claim Optical Benefits

To receive vision care services, simply call the Fund Office to receive your authorized certificate voucher and then make an appointment at a GVS or Vision Screening location. If you use a non-GVS or Vision Screening provider you will be reimbursed for up to $250 every 24 months in eligible optical expenses. Contact the Fund Office for more information.

Adoption Benefits

This Plan provides an adoption allowance to active members of up to $5,000 for each legally adopted minor child who is adopted on or after July 1, 1998. This adoption allowance is not available when the child is a stepchild of, or related by blood to, the member or the member's spouse. Contact the Fund Office for more details.

Weekly Loss of Time Benefits

The Welfare Fund provides weekly loss of time benefits (i.e., Short Term Disability, or STD, benefits) for active members only. These benefits provide up to 26 weeks of income for active members who are unable to work due to non-work related injuries or illness (including disability due to pregnancy). *Benefits will not be paid for accidents or sickness arising out of or in the course of your employment.*

Active members that are unable to work due to non-work related disabilities may be eligible for up to 26 weeks of income. Members do not have to pay for these benefits. Weekly loss of time benefits are paid for entirely by contributing employer contributions. Your weekly loss of time benefits are guaranteed to be at least the same amount and duration payable under New Jersey and New York disability laws.

Disability Benefits for New Jersey Members

If your disability is due to sickness, your weekly loss of time benefits begin on the eighth day of disability. After you've received disability payments for three consecutive weeks, the State of New Jersey Disability Benefits Law allows you to receive payment for the first seven days of your disability.

Period of disability. The State of New Jersey defines "a period of disability" as the entire period of time during which you are continuously and totally unable to perform the duties of your employment. Under this definition, if you have two periods of disability due to the same or related cause or condition and separated by a period of not more than 14 days, it will be considered as one continuous period of disability, provided you have earned wages during such 14-day period with the employer who was your last employer immediately preceding the first period of disability.

Exclusions/limitations. The following exclusions and limitations apply under the Plan. Benefits are not payable under this Plan:

- For the first seven consecutive days of each period of disability; except that if benefits are payable for three consecutive weeks for any period of disability, then benefits will also be payable with respect to the first seven days;
- For more than 26 weeks for any one period of disability;
- For any period of disability which did not commence while you were a "covered individual," i.e., a person who is in "employment" as defined by the New Jersey Unemployment Compensation Law, for which you are entitled to remuneration from an employer covered by such Law, or who has been out of such employment for less than two weeks;
- For any period during which you are not under the care of a legally licensed physician, dentist, optometrist, podiatrist, practicing psychologist, advanced practice nurse or chiropractor, who when requested by the Plan or the New Jersey Division of Temporary Disability Insurance, will certify within the scope of his/her practice, your disability, the probable duration thereof, and where applicable, the medical facts within his/her knowledge;
- For any period of disability due to willfully and intentionally self-inflicted injury, or to injury sustained in your perpetration of a crime of the first, second or third degree; or
- For any period during which you perform any work for remuneration or profit.

Active members that are unable to work due to non-work related disabilities may be eligible for up to 26 weeks of income.

Non-duplication of benefits provision under New Jersey Temporary Disability Benefits Law:

The New Jersey Temporary Disability Benefits Law prohibits the payment of disability benefits:

- For any period during which benefits are paid or are payable under any unemployment compensation or similar law, or under any disability or cash sickness benefit or similar law of this State or of any other State or Federal government.

  However, if disability benefits are paid or payable to you under the disability benefit law of another State, or under the Federal maritime law, you may still be eligible for New Jersey benefits. In this circumstance your weekly benefit rate would be reduced by the amount paid concurrently under the other State or maritime law.

- For any period during which workers' compensation benefits are paid or payable, other than for permanent partial or permanent total disability previously incurred.

- Temporary disability benefits are reduced by the amount paid concurrently under any governmental or private retirement, pension or permanent disability benefit or allowance program to which a worker's most recent employer contributed on his/her behalf. However, please note that Social Security retirement benefits do not reduce State Plan temporary disability benefits.

Please contact the State of New Jersey Department of Labor and Workforce Development, P.O. Box 957, Trenton, New Jersey 08625 for more information regarding non-duplication of benefits provisions under the New Jersey Temporary Disability Benefits Law.

Disability Benefits for New York Members

If your disability is due to a non-work related accident, your weekly loss of time benefits begin on the first day of disability. If your disability is due to a sickness, then your benefits begin on the eighth consecutive day of disability.

Period of Disability. The number of periods of disability during any one year is unlimited. A period of disability means the entire period of time during which you are continuously and totally unable to perform the duties of your employment, except that two periods of disability due to the same or related cause or condition and separated by a period of not more than three months will be considered as one continuous period of disability, provided you have earned wages during such three-month period.

Exclusions/Limitations. Benefits are not payable for:

- More than 26 weeks during a period of 52 consecutive calendar weeks or during any one period of disability;

- Any period for which you are subject to suspension or disqualification of the accumulation of unemployment insurance benefit rights, or would be subject if you were eligible for such benefit rights, except for ineligibility resulting from your disability;

- Any disability due to any act of war, declared or undeclared;

- Any disability commencing before you become eligible for benefits under this Plan, but this shall not preclude benefits for recurrence of a disability commencing prior to your eligibility;

- Any disability occasioned by the willful intention to bring about injury to or sickness upon yourself or another, or resulting from any injury or sickness sustained in your perpetration of an illegal act;

- Any day of disability during which you performed work for remuneration or profit;

- Any period of disability during which you are not under the care of a duly licensed physician, a duly registered and licensed podiatrist of the State of New York, a duly registered and licensed chiropractor of the State of New York, a duly licensed dentist of the State of New York, a duly registered and licensed psychologist of the State of New York, a duly certified nurse midwife, or a practitioner duly accredited by a church or denomination to perform prayer or faith healing, and provided you submit to all physical examinations as required by this chapter; and

- Any day of disability for which you are entitled to receive from your employer, or from the Fund to which your employer has contributed, remuneration or maintenance in an amount equal to or greater than that to which you would be entitled under this Plan; but any voluntary contribution or aid which an employer may make to you or any supplementary benefit paid to you pursuant to the provisions of a collective bargaining agreement or from a trust fund to which contributions are made pursuant to the provisions of a collective bargaining agreement will not be considered as continued remuneration or maintenance for this purpose.

Non-Duplication of Benefits. No benefits will be payable under this Plan:

- For any week for which payments are received under the unemployment insurance law or similar law of this State or of any other State or of the United States;
- In a weekly benefit amount which, together with any amount that you receive or are entitled to receive for the same period or any part of such period as a permanent disability benefit or annuity under any governmental system or program (except under a veteran's disability program) or under any permanent disability policy or program of an employer for whom you have performed services, would, if apportioned to weekly periods, exceed your weekly benefit amount under this Plan, provided, however, that there will be no offset against the benefits under this Plan if the claim for disability benefits is based on a disability other than the permanent disability for which the permanent disability benefit or annuity was granted; or
- For any period for which benefits, compensation or other allowances (other than workers' compensation benefits for a permanent partial disability occurring prior to the disability for which benefits are claimed under this Plan) are paid or payable under the New York workers' compensation law or any other workers' compensation act, occupational disease act or similar law; or under any employers liability act or similar law; under any other temporary disability or cash sickness benefits act or similar law; under the Volunteer Firemen's Benefit Law; under Section 688, Title 46, United States Code; under the Federal Employers Liability Act; or under the Maritime Doctrine of Maintenance, Wages and Cure.

Your Death Benefits

You are eligible for death benefits while in covered employment and receiving active benefits. Pensioners who have retired with active coverage are also eligible for death benefits. Your life insurance coverage, which is paid by the Fund, is $35,000 for active members and $7,500 for pensioners. Death benefits are payable to your beneficiary if you die while coverage is in effect. Coverage will continue for 31 days after termination of eligibility, or for as long as you are totally and permanently disabled, provided your disability begins prior to age 60 and you are actually receiving benefits.

About Your Beneficiary

Your death benefit beneficiary is the same as your accidental death and dismemberment beneficiary unless you choose otherwise.

If you do not name a beneficiary, or if your beneficiary dies before you and you have not named a new beneficiary, your death benefit will be paid to your surviving spouse, or if you don't leave a surviving spouse, then to your estate.

The Plan does not pay life insurance benefits to a designated beneficiary who is involved in any way with the death of the participant.

When Coverage Ends

An active member's death benefits end 31 days after covered employment ends. Pensioners who have retired with active coverage maintain the death benefit coverage for his/her lifetime.

Claiming Death Benefits

Your beneficiary must notify the Fund Office in writing of your death. The Fund Office will send your beneficiary the appropriate claim form necessary to receive these benefits from the Plan.

Your Accidental Death & Dismemberment (AD&D) Benefit

The Accidental Death & Dismemberment (AD&D) Benefit, which is paid for and administered by the Local 14-14B Welfare Fund, is in effect 24 hours a day. It is worldwide protection that applies to accidents on or off the job, at home or away from home. You are eligible while in covered employment and for 30 days after your covered employment ends.

How AD&D Benefits Work

Your AD&D benefit coverage is shown in the following chart. Benefits are payable to your beneficiary if you die, or to you if you are severely injured in an accident (except those specifically excluded). AD&D benefits are payable in addition to any other coverage you may have.

Loss	Benefit Payable
Life	$35,000
Both hands at or above the wrist; both feet at or above the ankle; eyesight in both eyes; or any combination of hand, foot and eyesight	$35,000
One hand at or above the wrist; one foot at or above the ankle; or eyesight in one eye	$12,000
Thumb or index finger of either hand	$6,250

How a "loss" is defined. Loss of a hand or foot means the actual and complete severance through or above the wrist or ankle joint. Loss of eyesight means the irrevocable and complete loss of sight.

Only one amount—the largest to which the individual is entitled—will be paid for all losses resulting from a single accident. The loss must take place within 90 days after an accident for AD&D benefits to be payable. Any claim payable under the Plan must be filed within 90 days after a loss is incurred.

What's Not Covered

AD&D benefits are not payable if your loss is caused directly or indirectly, in whole or in part, by any of the following:

- Suicide or self-inflicted injury;
- Death or dismemberment that is not directly caused by an accidental injury; or
- Non-commercial air travel.

When Coverage Ends

AD&D insurance coverage ends when your welfare coverage ends.

Claiming AD&D Benefits

If you die as the result of an accident, your beneficiary or family member should contact the Fund Office as soon as reasonably possible.

If you lose a hand, foot or sight in one eye as the result of an accident, you should contact the Fund Office within 13 weeks of the accident. Notice of your loss should be sent to the Fund Office at:

International Union of Operating Engineers
Local 14-14B Welfare Fund
141-57 Northern Blvd
Flushing, NY 11354

Submitting an accidental death claim is a little more complicated than a death benefit claim because you have to prove that the death was the result of an accident.

If you submit a claim for dismemberment benefits, the Fund Office may require that you have a medical examination. The exam will be conducted by a doctor selected and paid for by the Fund.

You or your beneficiary must submit the completed forms to the Fund Office along with proof of AD&D and with any other requested information, and a copy of the death certificate if appropriate. See the section called “How to Claim Benefits” for more information.

How to Claim Benefits

This section describes the Plan's formal procedures for filing claims for benefits. It also describes the procedures to follow if you wish to appeal a claim that has been entirely or partially denied. Refer to the hospital carrier's Certificate of Coverage for the claims and appeals procedures for hospital benefits.

Definition of a Claim

A claim for benefits is a request for Plan benefits made in accordance with the Plan's claims procedures. The claims procedure varies depending upon the specific benefit you are requesting. The following are not considered claims for benefits:

- Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim.
- A request for prior approval of a benefit that does not require prior approval by the Plan.
- Presenting a prescription to a pharmacy that exercises no discretion on behalf of the Plan.

The claims procedure varies depending on:

- The *type of benefit* you're claiming. If you have to file a claim, it must be filed with the appropriate organization listed in this section.
- The *type of claim* you're filing. The different types of claims are described next.

How to File Claims

Your claim will be considered to have been filed as soon as it is received by the organization responsible for the initial determination of the claim. All claims must be submitted within six months after the expense was incurred. See the following chart for where to submit your claims.

In-Network Medical and Hospital	**No claim forms are required.** There are no claim forms for most in-network services as these providers will submit claims directly for payment.
Major Medical (Out-of-Network Claims)	If you go out-of-network for medical services, you will need to submit bills to: **International Union of Operating Engineers** **Local 14-14B Welfare Fund** **141-57 Northern Blvd.** **Flushing, NY 11354** **Phone: (718) 939-1489** All claims must be submitted within six months of the date of service.
Prescription Drug	No claim forms required. When you visit a participating Express Scripts pharmacy, you pay the cost-sharing amount directly to the pharmacist. For mail orders, obtain a Mail Service Order Form from the Fund Office and mail prescription(s) in the pre-addressed envelope. However, if your request for a prescription is denied in whole or in part, you may file a claim by contacting Express Scripts at: **Express Scripts** **3684 Marshall Lane** **Ben Salem, PA 19020-5997** You may call the Fund Office at (718) 939-1489 to obtain a pre-addressed envelope.

Dental: Delta Dental PPO	**In-Network (DeltaPreferred)** There are no claim forms for most in-network services. When you visit a network provider, you pay the cost-sharing amount, if any, directly to the provider. **Out-of-Network (DeltaPremier)** If you go out-of-network or use a non-participating provider for dental services, you will need to submit claim forms to: **Delta Dental of New York (Group #1925)** **One Dental Drive** **Mechanicsburg, PA 17055** You may also obtain a claim form from your provider or from Delta Dental's website at www.midatlanticdeltadental.com. You may also call the Fund Office at (718) 939-1489 to obtain a form.
Vision	**Vision vouchers are required and must be obtained from the Fund Office.** You simply present a voucher to Vision Screening or GVS. If you use an out-of-network provider, the Fund will reimburse eligible optical expenses up to $250 maximum every 24 months.
Weekly Loss of Time (Short Term Disability) Benefits	Submit claim forms and proof of eligibility to the Fund Office: **International Union of Operating Engineers** **Local 14-14B Welfare Fund** **141-57 Northern Boulevard** **Flushing, NY 11354**
Death Benefits	Submit claim forms and proof of eligibility (a death certificate) to the Fund Office: **International Union of Operating Engineers** **Local 14-14B Welfare Fund** **141-57 Northern Boulevard** **Flushing, NY 11354**
Adoption Benefit	You must submit a letter to the Fund Office and include a copy of the adoption papers.
Accidental Death & Dismemberment	Submit claim forms and proof of eligibility (e.g., a death certificate is proof of eligibility for the death benefit) to the Fund Office: **International Union of Operating Engineers** **Local 14-14B Welfare Fund** **141-57 Northern Boulevard** **Flushing, NY 11354**
Your claim will be considered to have been filed as soon as it is received at the Fund Office.	

When to File Claims

It is recommended that you file all claims, except weekly loss of time benefit claims, within six months following the date the charges were incurred. Claims for the Weekly Loss of Time benefits must be filed within 30 days of the start date of your disability.

Claims filed after the six month limit will not be paid.

A claim that has been mailed incorrectly to the Fund Office will be forwarded to the correct address by the Plan. The time frame imposed on the claim procedures will run from the date the claim is received at the appropriate address.

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. You can get a form from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an urgent care claim without your having to complete the special authorization form.

Making Claims Determinations

The time frames for deciding whether the Local 14-14B Welfare Fund accepts or denies a claim will vary depending on whether your claim is for **a death benefit claim,** an **accidental death and dismemberment claim,** an **adoption benefit claim,** a **concurrent health benefit claim** or **a post-service claim** or a **weekly loss of time benefit (disability) claim.** For information on hospital benefits, please refer to the hospital carrier's Certificate of Coverage.

Death benefit claims, AD&D claims and adoption claims. The Fund Office will make a decision on a death benefit claim, AD&D claim or adoption claim and notify your beneficiary within 90 days of receipt of the claim. If the Fund Office requires an extension of time due to special circumstances, you will be notified of the reason for the delay and when the decision is expected to be made. This notification will occur before the expiration of the 90-day period. A decision will be made within 90 days of the end of the initial 90-day period.

Pre-service. There are currently no pre-certification requirements under the Plan and no pre-service claims.

Concurrent health benefit claims. A concurrent claim is a claim relating to an ongoing course of health benefit treatment approved by the Plan, which is provided to you over a period of time or for a specified number of treatments. If you are receiving such an ongoing course of treatment and it is reduced or terminated before the end of the previously approved treatment period (other than by Plan amendment or termination), such reduction or termination is considered a concurrent claim. (An example of this type of claim would be an in-patient hospital stay originally certified for five days that is reduced to three days after, upon review, it is determined that the full five days is inappropriate). You will be notified of the adverse benefit determination sufficiently in advance of the reduction or determination to allow you ample time to request a review of the decision and obtain a determination upon review before the benefit is reduced or terminated. If you request to extend a course of treatment beyond the approved period of time or number of treatments, such a request is considered a concurrent claim. The insurer or the Fund Office, whichever is the appropriate party, will make a determination in accordance with the rules for post-service claims (description follows).

Post-service claims. The following procedure applies to post-service claims (for health benefits). A post-service claim is a claim that is submitted for payment after health services and treatment have been obtained. The following is the general procedure for filing a post-service claim:

1. You or your provider must obtain a claim form.
2. Have your provider either complete the attending physician's statement section of the claim form, submit a completed HIPAA Compliance Federation of America (HCFA) health insurance claim form, or submit a HIPAA-compliant electronic claims submission.
3. You or your provider must attach all itemized hospital bills or doctor's statements that describe the services rendered.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

Ordinarily, you will be notified of the decision on your post-service claim within 30 days from the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days if the extension is necessary due to matters beyond the Plan's control. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

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

Weekly loss of time benefit (disability) claims. The Plan will make a decision on the claim and notify you of the decision within 45 days. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the date on which the Plan notifies you of the delay. The period for making a decision may be delayed an additional 30 days, provided the Plan Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date on which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Plan's request for the information, you will be notified of the Plan's decision on the claim within 30 days.

For weekly loss of time benefit claims, the Plan reserves the right to have a physician examine you (at the Plan's expense) as often as is reasonable to determine your disability status. You can appeal a denial, in whole or part, of weekly loss of time benefits to the Board of Trustees, or to the New York Workers' Compensation Board or the New Jersey Division of Unemployment and Disability Insurance. This section describes procedures applicable to appeals to the Board of Trustees.

Claims Denial Notification

The Plan will notify you in writing if your claim has been denied, either in full or in part. This notice will state:

- The specific reason(s) for the denial;
- Reference to the specific Plan provision(s) on which the denial is based;
- A description of any additional material or information necessary to support the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review; and
- With respect to claims other than for death benefits, accidental death and dismemberment benefits or adoption benefits, if an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge; or, if the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Appealing a Denied Claim

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. The appeal process is intended to provide you with a full and fair review of your claim and benefit denial decision. The process is as follows:

- You must file your appeal within 180 days of the date you receive the Notice of Benefit Denial.
- You may submit written comments, documents, records and other information relating to the claim.
- You are entitled to receive, upon request and free of charge, access to copies of documents, records, and other information relevant to your claim for benefits. Information that is relevant to your claim may include:
  - Information that the Plan relied upon, considered or generated in the review of your claim;
  - Information that was submitted to the Fund Administrator for the claims review;
  - Information that shows that the Plan made the claims decision consistently and according to the Plan documents; or
  - Information that may constitute a statement of Plan policy or guidance regarding your benefit.

If you would like to request relevant information, please contact the Fund Administrator.

Appeals for denied, medical, prescription drug, optical expense, death and accidental death and dismemberment and adoption benefits must be made to the Board of Trustees by writing the Fund Office at the following address:

International Union of Operating Engineers
Local 14-14B Welfare Fund
141-57 Northern Boulevard
Flushing, NY 11354

Your request for review of a denied medical, prescription drug or optical expense must be made within 180 days after you receive notice of denial of your claim, in whole or in part. Your request for review of a denied claim for death benefits, accidental death and dismemberment benefits or adoption benefits must be made within 60 days after you receive notice of denial.

For appeals of hospital benefits, the appeal should be submitted to the hospital carrier. Contact the Fund Office for assistance.

The Plan does not review denied claims requested by providers of health services and/or treatment.

Dental Claims. If your appeal to Delta Dental is denied, you may undergo a second level of appeal with Delta Dental. You have 180 days from the date on the notice of the letter denying your first appeal to submit your written request for a second appeal to the address listed on page 45, with any additional information you have in support of your request.

Review Process

The Board, which meets quarterly, makes benefit determinations no later than the date of the Board meeting immediately following the Plan's receipt of a request for review, unless the request for review is filed within 30 calendar days preceding the date of such meeting. In that case, a benefit determination may be made no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time describing the special circumstances and the date the benefit determination will be made, the Fund Administrator will notify you of the benefit determination no later than five days after the benefit determination is made.

Timing of Notice of Decision on Appeal

With respect to Major Medical, prescription drug, death benefits, accidental death and dismemberment, adoption and optical benefits, ordinarily, decisions on appeals involving post-service claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

With respect to dental benefits, you will be sent a notice of decision on review within 30 days of receipt of the appeal by Delta Dental. If your appeal is denied, and you choose to undergo Delta Dental's second level of appeal, you will be sent a notice of decision on second review within 30 days of receipt of the second appeal by Delta Dental.

With respect to hospital claims, you will be sent a notice of decision from the hospital carrier in accordance with the procedures described in their Certificate of Coverage.

Notice of Decision on Review

The Plan will notify you in writing of its decision on your appeal of a denied claim.

This notice will provide: the specific reason(s) for the determination; reference the specific plan provision(s) on which the determination is based; a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge; and a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge; and if the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Please note that you may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under ERISA Section 502(a) without exhausting these appeal

procedures if the Plan has failed to follow them. No lawsuit may be started more than three years after the end of the year in which the services were provided.

Incompetence

In the event it is determined that a claimant is unable to care for his/her affairs because of illness, accident or incapacity, either mental or physical, any payment due may, unless claim has been made therefore by a duly appointed guardian, committee or other legal representative, be paid to the spouse or such other object of natural bounty of the claimant or such person having care and custody of the claimant or such person having the claimant's power of attorney, as the Board of Trustees will determine in its sole discretion.

Cooperation

Every claimant will furnish to the Board of Trustees all such information in writing as may be reasonably requested for the purpose of establishing, maintaining and administering the Fund. Failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payment of benefits. The Board of Trustees will be the sole judge of the standard of proof required in any case, and from time to time may adopt such formula, methods and procedures as the Board considers advisable.

Mailing Address

In the event that a claimant fails to inform the Board of Trustees of a change of address and the Board is therefore unable to communicate with the claimant at the address last recorded and a letter sent by first class mail to such claimant is returned, payments due the claimant will be held without interest until payment is successfully made.

Recovery of Overpayment

If you are overpaid or otherwise paid in error for a claim, you must return the overpayment. The Board of Trustees will have the right to recover any benefit payments made in reliance on any false or fraudulent statement, information or proof submitted, as well as any benefit payments made in error. Amounts recovered may include interest and costs.

In the event you are overpaid, the Fund Office will request a refund or the overpayment will be deducted from future benefits.

If payment is made on the eligible Plan participant's behalf to a hospital, doctor or other provider of health care and that payment is found to be an overpayment, the Fund will request a refund of the overpayment from the provider. If the refund is not received, the amount of the overpayment will be deducted from future benefits, or a lawsuit may be initiated to recover the overpayment.

Other Information You Should Know

Coordination of Benefits (COB)

Members of a family are often covered by more than one group health insurance plan. As a result, two or more plans may provide coverage for the same expense. To determine which plan pays first, the Plan includes a Coordination of Benefits (COB) provision for all covered benefits with the exception of death and AD&D benefits. See the hospital carrier's Certificate of Coverage for the coordination of benefit rules related to your hospital benefits.

Coordination of Benefits operates so that one of the plans (called the "primary plan") pays benefits first. The secondary plan may then pay the difference up to the allowable expenses. Here's how the order of payment between the two plans is determined.

Member/dependent. The plan that covers you as a member is primary, and the plan that covers you as a dependent is secondary. If you are insured as an active employee under more than one health insurance plan, the plan that has provided coverage for you the longest will be the primary plan.

Transferring members. For transferring union members, the other local union's coverage will be primary and the Local 14-14B Welfare Fund coverage will be secondary until primary coverage is exhausted. Contact your local Fund Administrator for more details.

Dependent child/parents not divorced or separated. If a dependent child is covered under both parents' plans, the plan of the parent whose birthday is earlier in the year will pay first (this is often referred to as the "birthday rule"). For example, if one parent was born on August 4 and the other parent was born on November 11, the plan of the parent born on August 4 is primary because August 4 is earlier in the year. If the parents have the same birthday, the plan that covers a parent longer will pay first. If the other plan does not follow the birthday rule, then the father's plan will be the primary plan.

Dependent child/parents divorced or separated. If a plan has received notice of a Qualified Medical Child Support Order (QMCSO) that orders one of the parents to provide coverage, the plan indicated in the QMCSO will pay first. If there is no QMCSO, the plan of the parent with custody of the child pays benefits first or as indicated in the divorce decree.

How Much This Plan Pays When It Is Secondary:

When this Plan pays second, it will pay 100% of **"Allowable Expenses"** less whatever payments were actually made by the plan (or plans) that paid first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid during the Plan Year had it been the plan that paid first. This has the effect of maintaining this Plan's deductibles, coinsurance and exclusions. As a result, when this Plan pays second, you may not receive the equivalent of 100% of the total cost of the covered health care services.

"Allowable Expense" means a health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- The difference between the cost of a semi-private room in a hospital or specialized health care facility and a private room, unless the patient's stay in a private hospital room is medically necessary.
- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

- If the other coordinating plan determines benefits on the basis of usual and customary charges, this Plan will use the negotiated amount as the allowable expense.
- When benefits are reduced by a primary plan because a covered participant did not comply with the primary plan's provisions, such as the provisions related to utilization management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

Allowable expenses **do not include** expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

Administration of COB. The Fund reserves the right to do the following in order to administer the COB provisions: exchange information with other plans involved in paying claims; require that you or your health care provider furnish any necessary information; reimburse any plan that made payments this Fund should have made; and recover any overpayment from your hospital, physician, dentist or other health care provider, other insurance company, you or your dependent.

If the Fund should have paid benefits that were paid by any other plan, it may pay the party the amount the Board of Trustees (or its designee) determines to be proper under the COB provision. Any amounts so paid will be considered to be Fund benefits, and the Fund will be fully discharged from any liability it may have to the extent of such payment.

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan participant may have against the other plan, and the Plan participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

Coordination with Medicaid. If your eligible dependents have coverage from the Fund and Medicaid, the Fund will be the primary insurer.

Coordination with CHAMPUS. If both the Fund and CHAMPUS cover you and/or your dependents, the Plan pays first, and CHAMPUS provides secondary coverage.

Motor vehicle no-fault coverage required by law. If you and/or your dependents are covered for medical benefits by both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage is solely responsible for payment. There is no coverage through this Plan.

Other coverage provided by state or Federal law. If you and/or your dependents are covered by both this Plan and any other coverage provided by any other state or Federal law, the coverage provided by any other state or Federal law pays first, and the Plan pays second.

Coordination with workers' compensation. If you're receiving benefits for a particular condition through workers' compensation insurance or a similar program, workers' compensation provides your primary and only coverage for that particular condition. Plan coverage remains in effect, excluding coverage for the particular condition that warranted workers' compensation benefits.

Medicare Coverage

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

Medicare Participants Who Retain or Cancel Coverage Under This Plan

If you, your covered spouse or dependent child become covered by Medicare, you may either retain or cancel your coverage under this Plan. If you choose to retain your coverage under this Plan, as long as you remain actively employed, your health

care coverage will continue to provide the same benefits and your contributions for coverage will remain the same. The Plan will pay first and Medicare will pay second.

If you choose to cancel your coverage under this Plan, coverage of your spouse and/or dependent child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. Please refer to page 11 for further information about COBRA Continuation Coverage.

- **Coverage Under This Plan and Medicare When You Are Totally Disabled**

  If you become totally disabled and you are entitled to Medicare because of your disability, you will no longer be considered "actively employed." As a result, once you become entitled to Medicare because of your disability, Medicare will become your primary plan and will pay first, with this Plan paying second.

- **Coverage Under This Plan and Medicare When You Have End-Stage Renal Disease**

  If, while you're actively employed, you or any of your covered dependents become entitled to Medicare because of End-Stage Renal Disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of:

  – The month in which Medicare ESRD coverage begins; or

  – The first month in which the individual receives a kidney transplant.

On the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Coverage Under Medicare for Pensioners and their Dependents

If a pensioner is not actively working (e.g., retired) and is covered by Parts A, B, C and/or D, as well as this Plan, Medicare pays first and this Plan pays second. Those enrolled in any Part of Medicare may either retain or cancel coverage under this Plan. If a pensioner under this Plan is covered by Medicare and cancels coverage under this Plan, coverage for his/her dependent(s) will terminate, but they may be entitled to COBRA Continuation Coverage. See the Continuation of Coverage chapter for further information about COBRA Continuation Coverage. If any of the dependents are covered by Medicare and the pensioner cancels a dependent's coverage under this Plan, that dependent will not be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan of a Medicare beneficiary is the responsibility of you, the pensioner.

How Much This Plan Pays When It Is Secondary to Medicare

When Covered by Medicare Parts A or B: When an pensioner or dependent of a pensioner is covered by Medicare Parts A and B, this Plan will be secondary to Medicare. In such cases, this Plan pays the Part A deductible and coinsurance and the Part B deductible and coinsurance amounts not payable by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the usual and customary charges of the health care provider.

When Covered by Medicare Part D: If an eligible participant or eligible dependent enrolls in a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Plan with prescription drugs (MA-PD), he or she will not be eligible to receive benefits for any prescription drug benefits under this Plan.

Why you enter into a Medicare Private Contract: Under the law, a Medicare beneficiary is entitled to enter into a Medicare private contract with certain health care providers under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that provider. If you or an eligible dependent enters into such a contract, this Plan will NOT pay any benefits for any health care services and/or supplies you receive pursuant to it.

Enrolling in Medicare

It is important that you or your eligible dependent visit an office of the Social Security Administration during the three-month period prior to the 65th birthday to learn all about Medicare. For questions about coverage by this Plan, or help in comparing benefits offered by this Plan and Medicare, please contact the Fund Office.

Subrogation and Reimbursement

Although no benefits are payable under the Local 14-14B Welfare Fund for medical expenses, disability income benefits or any other benefit (except the death benefit) which are included or includable by any claim or lawsuit instituted by a covered member and/or covered dependent as against any third party, the Local 14-14B Welfare Fund may advance payment on account of Plan benefits subject to its right to be reimbursed by the participant for the full amount of such advance payment if and when there is any recovery from any third party. By accepting such an advance, the covered member and/or covered dependent agree that the Plan will be subrogated to the covered member and/or covered dependent's right of recovery from a third party or that third party's insurer for the entire amount advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule.

The right of reimbursement will apply:

- Even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical, disability income or other benefit expenses for which the advance was made; and
- Even if the recovery is not sufficient to make the ill or injured member and/or dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and without any reduction for legal or other expenses incurred by the member and/or dependents in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule); and
- Even if the recovery was reduced due to the negligence of the covered member or covered dependent(s) (sometimes referred to as "contributory negligence"), or any other common law defense.

Reimbursement and subrogation agreement. The covered member and/or any covered dependent on whose behalf the advance is made, shall be required to execute the Plan's subrogation and reimbursement agreement. In the event that the agreement is not executed, the Plan may refuse to make any advance, but if, at its sole discretion, the Plan makes an advance in the absence of an agreement, that advance will not waive, compromise, diminish, release or otherwise prejudice the Plan's right to subrogation and reimbursement.

Cooperation with the Plan by all covered individuals. By accepting an advance, regardless of whether or not an agreement has been executed, the covered member and/or covered dependents each agree:

- To reimburse the Plan for all amounts paid or payable to the covered member and/or covered dependents or that third party's insurer for the entire amount advanced;
- That the Plan has the first right of reimbursement from any judgment or settlement;
- To do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and subrogation rights;
- To not assign the right of recovery to any third party without the specific consent of the Plan;
- To notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party alleged to be responsible for the injury or illness that resulted in the advance, or entering into any settlement agreement with that third party or third party's insurer based on those acts; and

- To inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

Confidentiality of Health Care Information

The Plan is required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. The official *HIPAA Privacy Notice,* which is distributed to all participants of the Plan, is summarized here.

The intent of HIPAA is to make sure that private health information that identifies (or could be used to identify) you is kept private. This individually identifiable health information is known as "protected health information" (PHI). The Plan will not use nor disclose your PHI without your written authorization except as necessary for treatment, payment, Plan operations and Plan administration, or as permitted or required by law. What's more, the Plan will implement administrative, physical and technical safeguards to ensure that your PHI remains confidential, intact, secure and available only to authorized users. The Plan also will ensure that there are reasonable and appropriate security measures to protect electronic PHI, and ensure that any agent, including a subcontractor to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect the electronic PHI.

The Plan also hires professionals and other companies to advise the Plan and help administer and provide health care benefits. The Plan requires these individuals and organizations, called "Business Associates," to comply with HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates (for example). That notice will describe your rights with respect to benefits administered by that individual/organization.

Under Federal law, you have certain rights where your PHI is concerned, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, change or correct the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services, if you believe your rights have been violated.

If you have questions about the privacy of your health information or if you would like a copy of the official *HIPAA Privacy Notice,* please contact the Fund Office.

Newborns' and Mothers' Health Protection Act of 1996

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, the doctor), after consultation with the mother, discharges the mother or newborn earlier. Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a doctor or other health care provider obtain authorization for prescribing a length of stay after childbirth of up to 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998 Notice

This notice is provided to you in accordance with the requirements of the Women's Health and Cancer Rights Act of 1998. Effective June 1, 1999, because the IUOE Local 14-14B Welfare Fund provides medical and surgical benefits in connection with mastectomy, the Plan will also provide benefits for certain reconstructive surgery. In particular, the Plan will provide, to a participant or beneficiary receiving or claiming benefits

in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications associated with all stages of mastectomy, including lymphedemas, in a manner determined in consultation between the attending physician and the patient.

This coverage is subject to applicable copayments, referral requirements, annual deductibles and coinsurance provisions. If you have any questions, please contact the Fund Office.

How Benefits May Be Reduced, Delayed or Lost

There are certain situations under which benefits may be reduced, delayed or lost. Most of these circumstances are spelled out in the previous sections, but your benefits will also be affected in the following situations.

- You or your beneficiary do not file a claim for benefits properly or on time.
- You or your beneficiary do not furnish the information required to complete or verify a claim.
- You or your beneficiary do not have your current address on file with the Fund Office.

You should also be aware that Fund benefits are not payable for enrolled dependents who become ineligible due to age, marriage or divorce (unless they elect and pay for COBRA benefits, described on page 11).

If any Plan mistakenly pays a bigger benefit than you're eligible for, or pays benefits that were not authorized by the Plan, the Plan may seek any permissible remedy allowed by law to recover benefits paid in error (also see "Recovery of Overpayment," page 50 and "Subrogation and Reimbursement," page 54).

Compliance with Federal Law

The Plan is governed by regulations and rulings of the Internal Revenue Service and the Department of Labor, and current Federal tax law. The Plan will always be construed to comply with these regulations, rulings and laws.

Amendment and Termination of the Plan

The Trustees of the Fund have the authority to amend or terminate the Plan at any time and for any reason. You will be notified if the Plan is amended or terminated; however, the change may be effective before a notice is delivered to you.

If the Plan is ended, Plan assets will be applied to provide benefits in accordance with the applicable provisions of Federal law.

Your Disclosures to the Plan

If you provide false information to the Plan or commit fraud, you shall be required to indemnify and repay the Plan for any losses or damages caused by your false statements or fraudulent actions. (Some examples of fraud include altering a check and knowingly cashing a voided check.) What's more, if the Plan makes payments as a result of false statements or fraudulent actions, the Board of Trustees may elect to pursue the matter by pressing criminal charges.

Plan Administration

The Fund is a welfare benefit plan. Fund assets are accumulated under the provisions of a Trust Agreement and are held in a Trust Fund for the purpose of providing benefits to participants and defraying reasonable administrative expenses. The Fund is administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees. The Fund's assets and reserves are invested by various investment advisors.

Discretionary Authority of the Board of Trustees

The Board of Trustees governs the Fund in accordance with an Agreement and Declaration of Trust. The Trustees have the sole and absolute discretionary authority to interpret the terms of the Plan, determine benefit eligibility, and resolve ambiguities or inconsistencies in the Plan. All determinations and interpretations made by the Board of Trustees and/or its duly authorized designee(s) shall be final and binding upon all participants, beneficiaries and any other individuals claiming benefits under the Plan.

The Board of Trustees has delegated certain administrative and operational functions to the Fund Manager and his/her staff. Most of your day-to-day questions can be answered by the Fund Office staff.

Collective Bargaining Agreements/ Employer Contributions

Benefits are provided pursuant to collective bargaining agreements. The Fund receives contributions according to collective bargaining agreements between your employer and Local 14-14B. These collective bargaining agreements provide that employers contribute to the Fund on behalf of each covered employee on a specified basis. Certain other employers (such as the Fund Office itself) may participate in the Plan by signing a participation agreement.

To find out whether a particular employer is contributing to the Fund on behalf of members working under a collective bargaining agreement or a participation agreement and, if so, to which plan of benefits the employer is contributing, contact the Fund Office. You can look at the collective bargaining agreements at the Fund Office or get your own copy upon written request to the Fund Office. The Fund Office will also provide you with, upon written request, a list of contributing employers.

No Liability for the Practice of Medicine or Dentistry

The Plan, the Trustees, and their designees are not engaged in the practice of medicine or dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, the Trustees, nor any of their designees will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Right to Offset

In the event any payment is made by the Plan to an individual who is not entitled to payment, the Plan shall have the right to reduce future payments payable to such individual by the amount of any erroneous payment. This right of offset, however, shall not limit the right of the Plan to recover overpayments in any other manner.

Facility of Payment

If the Plan Administrator or its designee determines that you cannot submit a claim or proof that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, Claim Administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the Local 14-14B Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to the following.

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Office and at other specified locations, such as work locations and union halls, all Plan documents governing the Plan, including insurance contracts, collective bargaining agreements, detailed annual reports, Plan descriptions, an updated summary plan description and a copy of the latest annual report (Form 5500 series) filed by the Plan with the Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information on written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a "qualifying event." You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage (see page 59).

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 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 in whole or in part, you have the 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 time schedules.

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

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

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

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

Certificate of Creditable Coverage. When your Local 14-14B Welfare Fund coverage ends, you and/or your dependents will be provided with a "Certificate of Creditable Coverage." Certificates of Creditable Coverage indicate the period of time you and/or your dependents were covered under the Fund (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy within 63 days after your coverage under this Fund ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for preexisting coverage periods that may apply to you and/or your dependents under the new group health plan or health insurance policy.

The Certificate of Creditable Coverage will be provided to you:

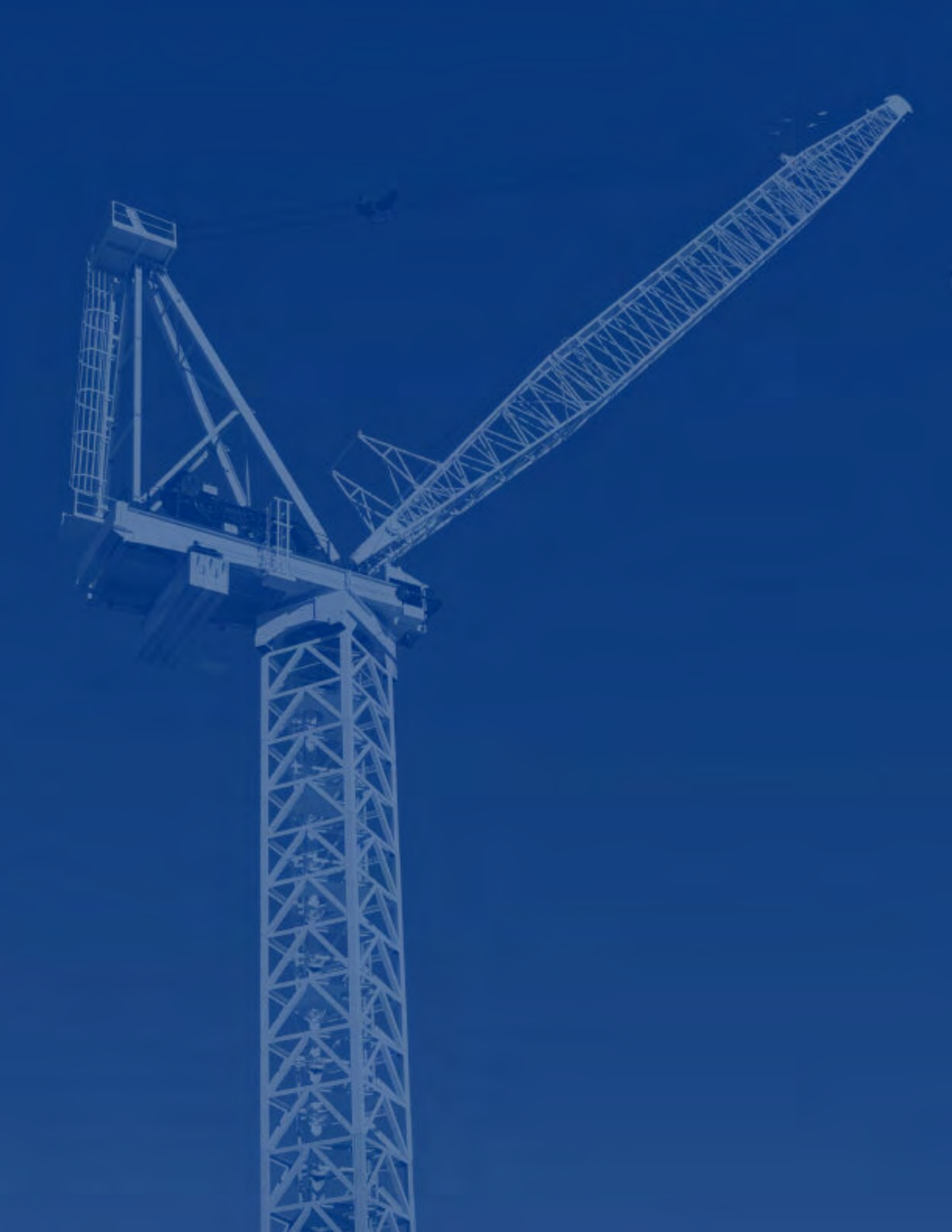
- On your request, within 24 months after your Fund coverage ends;
- When you are entitled to elect COBRA;
- When your coverage terminates, even if you are not entitled to COBRA; or
- When your COBRA coverage ends.

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

Notice of Privacy Practices Under HIPAA. This Plan is a covered entity under HIPAA's privacy regulations. For a copy of the Fund's "Notice of Privacy Practices," please contact the Fund Office.

Plan Facts

Official Plan Name	International Union of Operating Engineers Local 14-14B Welfare Fund
Employer Identification Number	11-2392159
Plan Number	501
Plan Year	July 1 – June 30
Board of Trustees	**Union Trustees** Edwin Christian Chris Confrey John Cronin Daniel Noesges **Employer Trustees** Francis P. DiMenna, General Contractors Assn. John O'Hare, Building Contractors Assn. John Hyers, Sr., Contractors Assn. of Greater N.Y. Al Gerosa, The Cement League
Fund Administrator	Judith A. Renick, Fund Manager 141-57 Northern Boulevard Flushing, NY 11354 Telephone: (718) 939-1489
Agent for Service of Legal Process	Legal process may be served on the Plan or on any member of the Board of Trustees at the address listed below. The Board of Trustees for the International Union of Operating Engineers Local 14-14B Welfare Fund 141-57 Northern Boulevard Flushing, NY 11354 For disputes arising under this Plan regarding hospital covered, service of legal process may be made upon the hospital insurer at one of their local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.
Type of Plan	This Plan is an employee welfare benefit plan that provides medical, prescription drug, dental, vision, weekly loss of time (short term disability), death, accidental death and dismemberment benefits and adoption benefits. The Fund self-insures and administers the medical, orthodontic, weekly loss of time (short term disability), adoption, death and AD&D benefits. The Dental PPO is self-insured and administered by Delta Dental. The prescription drug benefit is self-insured and administered by Express Scripts. The in-network optical benefit is self-insured and administered by General Vision Services and/or Vision Screening. The hospital benefits are provided in accordance with the provisions of the group policies issued by Group Health Insurance, Inc. (GHI) and are subject to their complete terms, conditions, limitations and exclusions. If a difference exists between the information in this SPD and the actual contracts, the contracts govern. Please consult the Certificate of Coverage/group contract for additional information.



Local 14-14B

10/07