Heat and Frost Insulators
Local No. 33 Health Fund

Summary Plan Description
2016 Edition

Heat and Frost Insulators
Local No. 33 Health Fund

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HEAT AND FROST INSULATORS

LOCAL No. 33

HEALTH FUND • PENSION FUND • ANNUITY FUND

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March 2016

To All Active Participants and Their Eligible Dependents:

We are pleased to provide you with this Summary Plan Description (booklet), which describes the benefits available to you and your eligible dependents through the Heat and Frost Insulators Local No. 33 Health Fund (the "Fund") as of January 1, 2016. All interested parties recognize the devastating financial consequences that can be incurred without health insurance and the importance of a comprehensive insurance program. We encourage you and your eligible dependents to take full advantage of the benefits and services offered by the Fund.

In addition to describing the benefits available to you as an active Employee, and to your eligible dependents, this booklet also describes the following:

- The eligibility rules for obtaining and continuing your coverage in the event you cease working in Covered Employment.
- The conditions governing the payment of benefits.
- The procedures you must follow when you are filing an out-of-network claim.
- How to file an appeal if your claim is denied in full or in part.

We urge you to read this booklet carefully. It has been written in a clear and concise manner so that you will fully understand the coverage available to you and your eligible dependents. We also suggest that you keep this booklet with your important papers so it will be readily available for future reference.

When changes are made to the Plan of Benefits, they will be communicated to you by a notice referred to as a Summary of Material Modification that will be sent to the last known mailing address the Fund Office has on file for you. If you change your mailing address, it is extremely important that you notify the Fund Office immediately.

If you have any questions about your health care benefits or would like assistance in filing a claim, please write or call the Fund Office. The staff will be pleased to assist you.

We wish you and your family the best of health in the years to come.

Sincerely,

BOARD OF TRUSTEES

NOTE: *The benefits described in this Summary Plan Description (SPD) are* ***not guaranteed*** *(vested) for any Participant, retiree, spouse or dependent. All benefits may be changed, reduced or eliminated at any time by the Board of Trustees, to the extent allowed by law. This*

SPD also sets out the information that must be given to Participants to comply with the Employee Retirement Income Security Act of 1974 (ERISA), including a statement of your rights and protections under that law. This information is located at the back of the SPD. This SPD supersedes and replaces all prior SPDs issued for the Heat and Frost Insulators Local No. 33 Health Fund.

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INTRODUCTION

This Plan is self-funded and is governed by federal law known as the Employee Retirement Income Security Act of 1974 (ERISA). This means that your health care claims are paid directly from Fund resources rather than by an outside insurance company, with the exception of Life Insurance and Accidental Death and Dismemberment (AD&D) benefits, which are insured.

Contributions are made by your Employer to a Trust in accordance with the terms of a collective bargaining agreement with Local Union No. 33. Because the Plan is self-funded, it is not subject to state insurance law. However, it is subject to federal laws.

Being self-funded also means that you have a responsibility to be an informed, conscientious health care consumer. Your individual efforts to conserve Fund resources have a direct effect on the cost of health care benefits provided to you and your family and on future benefit improvements.

Note that:

- The Fund has an agreement with Anthem Blue Cross/Blue Shield (Anthem) to access medical care through a Preferred Provider Organization (PPO), which is also called a "network." The major advantage to you in using Anthem's network of Physicians and Hospitals is that the Fund receives negotiated discounted fees and rates with the Physicians and Hospitals in the network, which are passed on to you. Your use of the network providers will also lower your out-of-pocket expenses, as the network plan of benefits generally requires that you pay a copayment at the time of service with the balance of charges generally paid in full. In addition, if you use a network provider, you are not required to submit claim forms to the Fund because the Anthem provider is required to submit claims electronically, on your behalf.
- To help conserve the Fund's assets and provide you with more efficient treatment, the Fund contracts with Hines & Associates to manage catastrophic claims and review all Hospital inpatient admissions and outpatient surgeries.
- The Fund contracts with OptumRx to allow you access and use of its retail and mail order Pharmacy network.
- Delta Dental of New Jersey administers the dental and orthodontic benefits.
- Davis Vision administers the vision network and vision benefits.
- Hearing benefits are provided through the University of Connecticut (UCONN) Speech and Hearing Clinic.
- Prudential Life Insurance Company insures the Life Insurance and Accidental Death and Dismemberment benefits.

SCHEDULE OF BENEFITS

FOR ACTIVE PARTICIPANTS ONLY

Plan Pays

Life Insurance.....$40,000

Accidental Death/Dismemberment Benefits
Principal Sum.....$40,000

Disability Income Benefits (non-work related)*
Maximum Weekly Payment—First 13 weeks. $300

Maximum Weekly Payment—Second 13 weeks…….....……...$200

Maximum Period of Benefit .....26 Weeks

**Benefits commence on the first day of Injury and on the eighth working day due to Illness. Benefits are not payable if retired and collecting a pension.*

FOR ACTIVE PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS

Lifetime Maximum Health Plan Benefit..... Unlimited

Calendar Year Health Plan Maximum..... Unlimited

Calendar Year Health Plan Deductible per Individual $500

Coinsurance (Fund pays) 80%

Out-of-Pocket Calendar Year Maximum.....$2,000 for an Individual; $4,000 for a Family

The Fund pays 100% of the covered expenses after satisfying the Out-of-Pocket maximum for the balance of the calendar year. All in-network charges, the deductible, coinsurance, and copayments, are accumulated toward your Out-of-Pocket maximum. A separate Out-of-Pocket maximum applies for prescription drugs. There is no Out-of-Pocket maximum for out-of-network services.

In-network covered preventive services and services requiring a copayment, including prescription drugs, dental, and vision benefits, are not subject to the deductible or coinsurance and, therefore, are not accumulated toward an Out-of-Pocket maximum.

IN-NETWORK BENEFITS

The Fund contracts with Anthem Blue Cross/Blue Shield for access to its provider network.

Except as otherwise noted, all Covered Charges are either subject to a Calendar Year Deductible and Coinsurance, or subject to a fixed dollar Copayment:

	You Pay
Routine Physical Exams/Preventive Care	$0. Paid in Full
Laboratory Services as part of Preventive Care	$0. Paid in Full
Physician Office Visit	$25 Copayment
Specialist Office Visit	$25 Copayment
Well Baby Care	$0. Paid in Full
Allergy Visit (For testing with the Copayment waived for allergy shots)	$25 Copayment
Chiropractic Visit	$25 Copayment Maximum 35 Visits per Calendar Year
Physical Therapy	$25 Copayment Maximum 60 Sessions per Calendar Year (Maximum # of Sessions Combined with Occupational Therapy and Speech Therapy)
Occupational Therapy	$25 Copayment Maximum 60 Sessions per Calendar Year (Maximum # of Sessions Combined with Physical Therapy and Speech Therapy)
Speech Therapy (restorative)	$25 Copayment Maximum 60 Sessions per Calendar Year (Maximum # of Sessions Combined with Physical Therapy and Occupational Therapy)
Diagnostic Laboratory (blood tests, etc.)	$25 Copayment
X-rays and Other Non-Advanced Imaging	$25 Copayment
Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.)	Discounted charges less than $2,000, Copayment of $200 Discounted charges in excess of $2,000, Copayment of $500
Surgery	Subject to Deductible and Coinsurance*
Anesthesia	Subject to Deductible and Coinsurance*
Emergency Room (In or Out-of-Network) The copayment is waived if omitted to the hospital	$200 Copayment
After-Hours Urgent Care Center	$100 Copayment

Walk-in Center ..... $50 Copayment

Ambulance (In or Out-of Network) ..... Subject to Deductible and Coinsurance*

Hospitalization ..... Subject to Deductible and Coinsurance*

Out-Patient Hospital Services ..... Subject to Deductible and Coinsurance*

Skilled Nursing Plan ..... Subject to Deductible and Coinsurance*
Maximum 60 Days per Calendar Year

Home Health Care ..... Subject to Deductible and Coinsurance*
Maximum 60 Sessions per Calendar Year

Hospice ..... Subject to Deductible and Coinsurance*

Durable Medical Equipment ..... Subject to Deductible and Coinsurance*

Mental Health and Substance Use Disorder: .....
Office Visit……..……..$25 Copayment
Hospitalization……..…..…Subject to Deductible and Coinsurance*

* Out-of-Pocket maximum applies.

OUT–OF-NETWORK BENEFITS (Non-Participating Physician or Other Provider)

If you (or your dependent) receive services from a non-participating provider Physician, Hospital or other laboratory facility), those charges are subject to the following deductible and coinsurance and are limited to Reasonable and Customary allowances. In addition, if a day or session maximum applies to the in-network benefit, the same number of visits or sessions are combined with and apply to the out-of-network benefit limitations.

You Pay

Deductible ..... $500 per Calendar Year

Coinsurance 20%
(Plan pays 80% of the Reasonable and Customary charges)

Out-of-pocket expenses do not include expenses that exceed the maximum allowance recognized by Anthem and expenses not covered by the Plan. .....

PRESCRIPTION DRUG BENEFITS (Available In-Network Only) (Administered by OptumRx)

You Pay

Retail Pharmacy (Up to a 30-day supply)

Generic Drugs	$10 Copayment per Prescription
Preferred Brand Name Drugs	$30 Copayment per Prescription
Non-Preferred Brand Name Drugs	$50 Copayment per Prescription

Mail Order Program (Up to a 90-day supply)

Generic Drugs	$20 Copayment per Prescription
Preferred Brand Name Drugs	$60 Copayment per Prescription
Non-Preferred Brand Name Drugs	$100 Copayment per Prescription

A separate Out-of-Pocket Calendar Year Maximum will apply to prescription drug copayments of $1,000 for an individual and $2,000 for a family.

NOTE: *No payment will be made by the Fund for any prescription drugs obtained outside the network of participating Pharmacies.*

DENTAL BENEFITS (Administered by Delta Dental of NJ)

Plan Pays

Preventive Care Services	100% of Covered Services
Basic Services	80% of Covered Services
Major Services	50% of Covered Services

Oral Surgery is covered as a medical expense.

Maximum Calendar Year Benefit (does not apply to eligible individuals under age 19) $1,000

ORTHODONTIC BENEFIT (For Dependent Children Only)

Plan Pays

Benefit	50% Coinsurance
Lifetime Benefit Maximum	$2,000

VISION BENEFITS

Plan Pays

Eye Examination ..... Once Every 12 Months
(The annual examination restriction for in-network benefits does not apply to children under the age of 19)

Davis Vision Provider 100%

Out-of-Network Provider ..... Up to $42

Eyeglasses ..... Once Every 12 Months

Davis Vision Provider ..... Paid in Full
Applies to fashion/designer level frames from Davis Visions' frame collection
Frames other than those in frame collection--$111 credit applies

Out-of-Network Provider ..... Up to $39 (Frames)
Up to $28 (Single Vision Lenses)
Up to $38 (Bifocal Lenses)
Up to $46 (Trifocal Lenses)
Up to $75 (Lenticular Lenses)
Up to $39 (Progressive Addition Lenses)

Contact Lenses ..... Once Every 12 Months

Davis Vision Provider 100%
Applies to Davis Vision's contact lens collection
Non-Davis Vision contact lens collection--$105 credit applies

Out-of-Network Provider ..... Up to $150 (electives)
Up to $300 (when Medically Necessary)

Safety Eyeglasses in Addition to Regular Eyeglasses ..... Once Every 12 Months
Employees Only
In-network only. No out-of-network benefit applies

HEARING BENEFIT

Exclusive benefit provided through the UCONN Speech and Hearing Clinic

Plan Pays

Examination 100%

Fitting and Molds 100%

Hearing Aids 50%

The Hearing Benefit is available once every three (3) years unless recommended more frequently by an audiologist from the University of Connecticut Speech and Hearing Clinic.

1. ELIGIBILITY PROVISIONS

You and your dependent(s) will become eligible for coverage in accordance with the following rules, provided sufficient contributions have been made (and received at the Fund Office) by a participating Employer. No medical examination is required in order to become covered under this Plan.

INITIAL ELIGIBILITY

You and your dependent(s) will become initially eligible for benefits on the first day of the month following the month in which $4,500 in Employer contributions are received on your behalf in twelve (12) consecutive months.

Administrative Account

An Administrative Account will be maintained to hold the dollar amount necessary for you to maintain eligibility for a calendar quarter. On the last business day of each calendar quarter, $4,500 will be deducted from the dollars held in your Administrative Account and, if necessary, withdrawn for your Health Reimbursement Account (HRA), to maintain your eligibility for the next calendar quarter. The coverage periods are the following calendar quarters:

- January, February, March;
- April, May, June;
- July, August, September; and
- October, November, December.

Example:

For initial eligibility only, during the period January 1 through May 31st, the Fund receives $5,000 in contributions from your Employer. Effective June 1st, you have established eligibility for the months of June, July, and August, and $500 is held in your Administrative Account to be applied to the next eligibility period.

Held Amount

On the last business day of each calendar quarter, $4,500 will be withdrawn from your Administrative Account for eligibility for the next calendar quarter. Contributions for an additional $4,500 will be held in your Administrative Account to assure eligibility for the next subsequent calendar quarter's eligibility.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

As Employer contributions are received by the Fund, they are first reflected in your Administrative Account to establish eligibility and accumulate up to the additional $4,500 needed for eligibility for the next calendar quarter. Account balances in excess of the current eligibility amount ($4,500) plus the $4,500 needed to assure eligibility for the next calendar quarter are moved to your Health Reimbursement Account (HRA). At your direction, your HRA can be applied to satisfy the deductibles and coinsurance requirements of the Plan or used to pay for other recognized expenses permitted by the Internal Revenue Service (IRS).

You can submit claims to reimburse yourself from your HRA account for eligible expenses listed in IRS Publication 502, including deductibles, coinsurance, copayments, and other expenses that have been approved by the IRS. Refer to Section 4 for information on the HRA.

HRA Forfeiture

If your Health Reimbursement Account (HRA) does not have any Employer contribution activity for twenty-four (24) consecutive months, your HRA balance will be forfeited, unless you are retired and collecting a retirement benefit from the Heat and Frost Insulators Local No. 33 Pension Fund.

CONTINUING ELIGIBILITY

On the last business day of each calendar quarter, $4,500 will be deducted from your Administrative Account to continue your eligibility for the next calendar quarter.

If, on the last business day of a calendar quarter, your Administrative Account is less than the required $4,500 to maintain eligibility for the next calendar quarter, any dollars in your HRA account will be moved back to your Administrative Account to bring the Administrative Account up to the required $4,500 to maintain eligibility. Any excess dollars will remain in your HRA account. In other words, you need to maintain a balance of $4,500 in your Administrative Account in order to have dollars in your HRA.

Example: Assume you have $8,000 in your Administrative Account on June 30th.

The Fund will withdraw $4,500 from your account to maintain your eligibility for the months of July, August and September. This will leave a balance of $3,500 in your Administrative Account. This balance will be held in your Administrative Account to maintain your eligibility for the calendar quarter beginning October 1st.

Subsequently, during the month of July, the Fund receives $2,000 in contributions on your behalf, increasing your Administrative Account balance to $5,500. At this time in July, you have satisfied the $4,500 required to maintain your eligibility for the **next** calendar quarter (October, November and December) and you have $1,000 left over. That $1,000 will be transferred into your HRA and you can use it to pay deductibles, your coinsurance, and other IRS-approved expenses.

Example: Assume you have $7,000 in your Administrative Account on June 30th.

The Fund will withdraw $4,500 from your account to maintain your eligibility for the months of July, August and September ($1,500 for each month). This will leave a balance of $2,500 in your Administrative Account, which will be held to maintain your eligibility for the calendar quarter beginning October 1st.

If no additional Employer contributions have been received, you will be notified on October 1st that your account balance can ***only*** maintain your eligibility for the month of October, and $1,500 will be deducted to do so. This will leave $1,000 in your Administrative Account. Since your account balance is less than the $1,500 required to maintain your eligibility for the month of November, you will be given the opportunity to make a self-payment for the short-fall ($500 in this example) to maintain your eligibility for November. If no Employer contributions are received by the Fund on your behalf, you will lose your eligibility unless you make a self-payment in the amount needed.

Continuing Eligibility if Disabled

If a participant becomes disabled and collects Weekly Disability Benefits from this Fund or Workers Compensation, for a claim with a contributing employer, your Administrative Account will be frozen for each week you collect disability benefits up to a maximum of thirteen (13) weeks. You must notify the Fund Office of your disability so your Administrative Account can be adjusted accordingly.

Self-Payment (Buy-In) and COBRA Continuation Coverage

If your account falls below $1,500 (the cost of one month of coverage), you will be allowed to make a self-payment covering the additional dollars needed for one month of coverage, after which time you will be able to receive benefits through COBRA continuation coverage.

> ***Example***: If on March 1st, your Administrative Account has $700 in it, you can self-pay the $800 and maintain eligibility for the month of March. Then you will be offered COBRA continuation privileges effective April 1st.

Note, however, **if you elect not to make a self-payment, you will be offered COBRA continuation privileges effective March 1st and the $700 will remain in your Administrative Account. If your Administrative Account remains dormant for 12 months (i.e. no Employer contributions are received on your behalf for 12 months), your balance will be forfeited**.

Option to Direct Annuity Fund Contributions to Your Health Fund Account

In order to help new hires gain eligibility earlier by accumulating $4,500 in their account, and assist Participants who wish to increase the balances in their accounts, the Local No. 33 collective bargaining agreement permits the redirection of contributions to the Health Fund. A new hire can elect to reduce the hourly contribution rate by $1 or $3 that would otherwise be paid to the Annuity Fund and have those contributions directed to the Health Fund. Each year, in the month of January, active Participants will have the same option to direct an additional $1 or $3 per hour that would be payable to the Annuity Fund to the Health Fund. This election must be in writing on a form provided by the Fund Office. This election is required to remain in force for a minimum of six (6) months. Once elected, a written notice must be provided to the Fund Office to retract this election.

Market Place Exchange Coverage

To obtain a subsidy from the Federal Government to help pay for coverage on an Exchange, you will have to forfeit any dollars remaining in your Administrative Account.

OPTING OUT OF PLAN COVERAGE

You can elect to opt out of coverage in the Plan if you provide the Fund Office with evidence that you are covered under an employer group comprehensive medical benefits plan through your spouse's employment. If you so elect, you will have $1,500 deducted quarterly from your Administrative Account. This deduction is for Life Insurance, AD&D and Weekly Disability benefits provided the Plan plus an appropriate share of administrative expenses for the calendar quarter. If you have opted out of coverage and have less than $1,500 in your Administrative Account, $500 will be withdrawn monthly.

Opt Out Held Amount

On the last business day of each calendar quarter, after the deduction of $1,500 for a current coverage period, any excess contributions will be transferred to a Health Reimbursement Account (HRA) on your behalf.

If on the last business day of a calendar quarter, your Administrative Account is less than the required $1,500 for a current coverage period, any dollars in your HRA account will be moved back to your Administrative Account to bring the Administrative Account up to the required $1,500 for the current coverage period. Any excess dollars will remain in your HRA account.

QUARTERLY STATEMENTS

At the beginning of each calendar quarter, you will receive a quarterly statement. The statement will reflect the following:

- Your beginning balance.
- Employer contributions received during the prior calendar quarter.
- Deductions for three (3) months of eligibility for the current coverage period, or if you've opted out, three (3) months of opt out deductions for the current coverage period.
- If sufficient $4,500 held in your Administrative Account (establishing eligibility for the next calendar quarter); or $1,500 for members who have opted out (for the next calendar quarter coverage).
- Your balance available in your HRA.
- Amounts paid from your HRA during the prior quarter, if any.

TERMINATION OF COVERAGE

If your account falls below $1,500 and you do not elect to continue coverage by making a self-payment for the outstanding balance, once the account has remained dormant for 12-months (i.e., Employer contributions have not been received), the balance in your account will be forfeited and your participation will end. To be reinstated, you will be required to satisfy the initial eligibility rules (i.e., have $4,500 in Employer contributions made on your behalf within six (6) consecutive months).

In addition, once you lose eligibility for coverage for a 12-month period, any unused credit in your Administrative Account will also be forfeited. This provision does not apply if you are retired and collecting a pension from the Local No. 33 Pension Fund.

If your Administrative Account falls below $1,500 and you do not pay the shortfall (balance of the $1,500) to maintain eligibility, you will be offered a COBRA self-payment option to maintain benefits. COBRA is also $1,500 per month to maintain coverage.

REINSTATING ELIGIBILITY

If you lose eligibility, you will be reinstated for benefits coverage on the first day of the month following the month that the Fund receives $1,500 in contributions on your behalf, provided the contributions are received within a 12-month period from the date you lost eligibility.

If you lose eligibility for more than 12 consecutive months, you will be required to meet the initial eligibility rules. The initial eligibility rules to be reinstated for coverage will be the first day of the month following the month that the Fund receives $4,500 in contributions on your behalf.

RESCISSION OF COVERAGE

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 60 days advance written notice of that rescission of coverage. The Board of Trustees has the right to determine, in its sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, or a material omission. The following situations will not be considered rescissions of coverage and do not require the Plan to give you 60 days advance written notice:

- The Plan retroactively terminates your eligibility because of your failure to pay the required balance or COBRA payment in a timely manner.
- The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your spouse and children were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Plan to give you advance written notice.

FAMILY AND MEDICAL LEAVE

Your eligibility for FMLA leave and benefits will be determined by your contributing Employer. If you have a question regarding your eligibility for FMLA leave, please contact your Employer.

You are eligible for a leave under FMLA if you:

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

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

- The birth, adoption, or placement with you for adoption of a child;
- Your need to care for a seriously ill spouse, parent, or child;
- Your serious Illness; and
- A qualifying exigency, or urgent need for leave because your spouse, son, daughter, or parent is on active duty in the armed services in support of a military operation.

In addition, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member. The service member must be:

- Your spouse, son, daughter, parent, or next of kin;
- Undergoing medical treatment, recuperation, or therapy for a serious Illness or Injury incurred in the line of duty while in the armed forces; and
- An outpatient or on the temporary disability retired list of the armed services.

The Fund will maintain your eligibility status, provided your contributing Employer remits the required $1,500 per month to the Fund to maintain your coverage for each month FMLA leave is granted.

ELIGIBILITY FOR COVERAGE DURING MILITARY SERVICE

The Fund provides benefits to you and your covered dependents during your military service in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Please contact the Fund Office before you enter military service to receive details about how and to what extent your and your dependents' coverage can be maintained.

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes:

- Active duty.
- Active duty for training.
- Initial active duty for training.
- Inactive-duty training.
- Full-time National Guard duty.
- A period for which you are absent from a position of employment for an examination to determine your fitness for duty.

If you serve in the uniformed services for less than 31 days, your health care coverage will continue. If your service continues for more than 31 days, you may elect to continue coverage under the Plan by having contributions drawn from your Administrative Account or by making monthly self-payments for up to 24-months. Continuation coverage under USERRA will be administered in the same manner as COBRA continuation coverage and will run concurrently with COBRA continuation coverage.

Your coverage will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 24-consecutive months after your coverage would have otherwise ended.

However, your coverage will end at midnight on the earliest of the day:

- Your coverage would otherwise end as described above;
- Your former Employer no longer provides any health plan coverage to any Employee;
- Your self-payment is due and unpaid; or
- You again become covered under the Plan.

Your coverage ends on the first day of the month following the date you enter uniformed services and elect not to continue coverage. Your eligible dependents may continue coverage under the Plan by electing to continue having dollars drawn from your Administrative Account or and making self-payments for COBRA continuation coverage.

You need to notify the Fund Office in writing when you enter the military and when you return to Covered Employment. For more information about continuing coverage under USERRA, contact the Fund Office.

Reinstating Your Coverage After Military Service

Following discharge from military service, you may apply for reemployment with your former Employer in accordance with USERRA. Reemployment includes the right to elect reinstatement in the existing health coverage provided by your Employer, and resuming to have contributions deducted from your Administrative Account. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service.

Contact your Employer for more information about reemployment following discharge from military service.

SPECIAL ENROLLMENT EVENTS

Newly Acquired Spouse and/or Dependent Child(ren)

- If you maintain individual coverage and you acquire a spouse by marriage, or if you acquire any dependent children by birth, adoption or placement for adoption, you may enroll your newly acquired spouse and/or any dependent child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. Contact the Fund Office for information on how to enroll a new spouse or child. Eligibility is granted from the date of your marriage or the birth of your child.
- If you did not enroll your spouse or dependent child(ren) for coverage within 31 days of the date of your marriage or birth of a child, you may enroll your spouse or dependent child(ren) the first day of the month following notification and the submission of appropriate documentation to the Fund Office.

2. DEPENDENT ELIGIBILITY

INITIAL DEPENDENT ELIGIBILITY

Your dependents become eligible for coverage as follows:

- On the date you become eligible for coverage.
- If you marry after the date you initially became covered under the Plan, your spouse will become covered on the first day of the month after your marriage, provided you notified the Fund Office within 31 days of your marriage.
- If you have a newborn biological child, an adopted child or a child placed for adoption with you, such child will become covered on the date of birth (for a newborn biological child) or the date the child is adopted or placed in your home (for an adopted children), provided you notified the Fund Office within 31 days.

To ensure a new dependent receives coverage, **you must notify the Fund Office** within 31 days after you acquire the new dependent through marriage, birth, or adoption to ensure coverage for your dependent.

Your eligible dependents include:

- Your **spouse**, to whom you are legally married, provided your spouse is recognized as such by the laws of the state of Connecticut. Common law marriages, domestic partners and licensed civil unions are not recognized. Your spouse may remain an eligible dependent until the last day of the month in which divorce, annulment, or legal separation occurs.
- Your biological **children**, adopted children, children placed with you for adoption, foster children, or stepchildren, provided the child satisfies the dependent Eligibility Rules that follow, if applicable. The term "placed with you for adoption" means you have assumed and retained the legal obligation for the total or partial support of the child in anticipation of adoption of such child. Placement for adoption terminates upon the termination of such legal obligation. Your child may remain an eligible dependent until the last day of the month following the month in which the child reaches age 26.

Other Dependent Eligibility Rules

- If your eligible dependent child is employed and becomes eligible for other group health coverage, the plan (other than this Plan) under which s/he is an Employee will be considered the primary plan for coverage. This Plan will pay secondary in the coordination of benefit payments.
- If a dependent child age 26 or older is incapable of self-sustaining employment because of a mental or physical disability and is financially dependent upon you for support (51% or more), his or her coverage may be continued under this Plan provided the disability began prior to the dependent child attaining age 26. You must submit proof of your dependent child's disability to the Fund Office no later than 31 days after you are requested to provide such proof. Proof of the continued existence of such disability is required by the Fund Office.
- In order for adopted children, children placed with you for adoption, or foster children to be considered eligible dependents, you must provide the Fund Office with appropriate documentation, satisfactory to the Plan in its sole discretion, such as adoption papers or a court order appointing you as the legal guardian for the child.

- In order for a **stepchild** to be considered an eligible dependent, the Fund **requires** the natural parents to provide a copy of any and all documentation, including paternity papers, court order, state order, and/or divorce decree setting forth the relationship with the child (for example, a copy of the child's birth certificate or certificate of adoption).
- If a dependent child is eligible for benefits under this Plan both as an active Participant and as your dependent child, s/he will not be considered an eligible dependent. However, if an eligible spouse is eligible for benefits under this Plan as an active Participant, benefits will be payable first as a Participant, then as a dependent. In no event will benefits exceed 100% of Covered Charges incurred.

The Fund Office will require all Participants to provide documentation substantiating an individual's right to status as an eligible dependent. The documentation required by the Fund Office includes:

- Marriage Licenses.
- Certificates of live birth showing both parents' names.
- Court (legal) documents showing legal guardianship/adoption.
- Acknowledgement of paternity.
- Notarized affidavits.

CHANGE IN FAMILY STATUS

After your coverage becomes effective, it is necessary to notify the Fund Office in writing of any of the following changes in your family status:

- Your marriage;
- Birth or adoption of a child;
- A child attaining age 26 or otherwise no longer meeting the definition of an eligible dependent under the Plan; and
- Death, divorce, or legal separation.

This is very important because the COBRA election period to continue coverage by self-payment is for a limited time and the **failure by you or your eligible dependent to notify the Fund Office of such a change may result in a loss of COBRA rights** for which you and/or your dependent could have been eligible.

In addition, failure to file the required information may delay payment of any benefits to you or your eligible dependents.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

The Plan is required to recognize Qualified Medical Child Support Orders (QMCSOs). QMCSOs require health plans to recognize state court orders, which the Plan finds to be Qualified Medical Child Support Orders, as defined in the Social Security Act, directing a Participant to provide health benefit coverage for dependent children, even if the Participant does not have custody of the children.

Under federal law, a QMCSO is a child support order of a court or state administrative agency that has been received by the Fund Office, and that:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by QMCSO;

- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined; and
- States the period for which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide. For a state administrative agency order to be a QMCSO, state law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any of your dependent children, the Plan Administrator will determine if that order is a QMCSO as defined by federal law, and that determination will be binding on you, the other parent, the child and any other party acting on behalf of the child. If an order is determined to be a QMCSO, the Plan Administrator will notify the parents and each child, and advise them of the Fund's procedures that must be followed to provide coverage to the dependent child(ren).

Coverage of the dependent child(ren) will be subject to all terms and provisions of the Plan, including any limits on the selection of providers, and requirements for authorization of services, insofar as is permitted by applicable law.

No coverage will be provided for any dependent child under a QMCSO unless all of the Plan's requirements for coverage of that dependent child have been satisfied. Coverage of a dependent child under a QMCSO will terminate when your coverage terminates for any reason, subject to the dependent child's right to elect COBRA Continuation Coverage (if that right applies).

If you have any questions about QMCSOs, contact the Fund Office.

TERMINATION OF DEPENDENT COVERAGE

Your eligible dependent's coverage under the Plan will terminate on the earliest of the following dates:

- The date your coverage under the Plan ends.
- The last day of the month during which your dependent no longer meets the definition of an eligible dependent.
- The date the Plan is terminated or amended to exclude coverage for the dependent.

3. RECIPROCAL AGREEMENTS

The Board of Trustees has entered into reciprocal agreements with other Heat and Frost Insulator (Asbestos) local health and welfare funds that provide for the transfer of contributions for work you perform outside the jurisdiction of Local No. 33 while you are participating in this Fund.

The provisions that govern the transfer of contributions on your behalf to this Fund for work performed in the jurisdiction of another local health fund may be unique to each reciprocal agreement, although strides have been made to standardize the agreements. Each agreement provides for an exchange of contributions necessary in computing eligibility. **Therefore, if you work outside the territory of Local No. 33, you should notify the Fund Office. This will permit the Fund Office to contact that health and welfare fund so that arrangements can be made to have contributions transferred to this Fund in an expeditious manner.**

You should stay in contact with the Fund Office any time you are working outside the jurisdiction of Local No. 33. The Fund Office needs to know the local's jurisdiction where you are working, your Employer, and roughly the amount of hours you have worked, in order to follow-up on reciprocal payments from other locals. Without this information, there is no means to follow-up with other health and welfare funds to assure contributions are reciprocated in a timely manner on your behalf.

Although the Board of Trustees will make every effort to collect amounts due from other funds under reciprocal agreements, they cannot enforce collection from Employers who are not signatory to the collective bargaining agreement with Local No. 33. Collection can only be enforced by the fund in the jurisdiction where the work was performed.

4. YOUR HEALTH REIMBURSEMENT ACCOUNT

Realizing that Participants have various types of health care expenses, the Fund offers a Health Reimbursement Account (HRA), which gives you the financial flexibility to use the Plan in the way that best meets your and your family's needs.

HRA HIGHLIGHTS

The HRA is designed to provide reimbursement of certain health care expenses on a tax-free basis. Here's how the HRA works:

- You work for a contributing Employer that contributes to the Fund on your behalf.
- As Employer contributions are received throughout the month, they will first be added to the Administrative Account to accumulate up to the required amount of $4,500 to maintain eligibility for a calendar quarter.
- Once Employer contributions are accumulated for you to maintain coverage for the next calendar quarter, any excess dollars will be moved to an HRA account established in your name. Essentially, at the beginning of any calendar quarter, before deducting dollars to maintain eligibility, your account balance is in excess of $9,000.

The Plan will establish and maintain an HRA for each eligible Participant but will not create a separate fund or otherwise segregate assets for this purpose.

HRAs are only record keeping accounts, and are used to keep track of contributions and reimbursement amounts.

- If, on the last business day of a calendar quarter, your Administrative Account is less than the required $9,000 for the upcoming two coverage periods, any dollars in your HRA account will be moved back to your Administrative Account to bring your Administrative Account up to the required $9,000 needed for the two coverage periods. Any excess dollars will remain in your HRA account.
- If your HRA does not have any Employer contribution activity in 12 consecutive months, your HRA balance will be forfeited, unless retired and collecting a monthly retirement benefit from the Local No. 33 Pension Fund.
- You determine how you want to use the money in your HRA. You can use it as you incur eligible health care expenses or save up and use the funds for future health care expenses.
- To seek reimbursement from your HRA, you must submit a reimbursement form to Insurance Programmers, Inc. indicating the date of service, provider, and the amount requested to be reimbursed.
- If your claim is paid by the Fund (Insurance Programmers, Inc.), no additional documentation is necessary. Prescription drug, dental, and vision claims require an itemized receipt or an itemized invoice and an Explanation of Benefits (EOB) along with a completed form.
- Money in your HRA and amounts reimbursed for eligible expenses are not included in your income, which means you aren't taxed on this money.
- If you have a balance in your HRA and you elect to purchase coverage on a Marketplace Exchange, you will forfeit your account balance. The Affordable Care Act (ACA) prohibits an individual from receiving a federal subsidy in an Exchange and maintaining any other Employer coverage, including an HRA.

- The funds in your HRA may only be used to pay for eligible health care expenses as defined by the Internal Revenue Service (IRS) Publication 502. However, a wide range of eligible expenses are covered, such as:
  - Payments for health coverage—including self-payment contributions to continue coverage, self-payments for COBRA continuation coverage, and post-tax premiums your spouse pays for other coverage.
  - Out-of-pocket Plan costs, such as deductibles, copayments, and coinsurance.
  - Qualified health care expenses not covered under the Plan, or only partially covered under the Plan, and expenses that exceed benefit maximums (where applicable).

We encourage you to read this section carefully to help you understand how your HRA works and how it can benefit you.

ELIGIBILITY

You are eligible for the HRA if you are eligible for coverage under the Plan. All eligibility provisions are the same as listed elsewhere in this Summary Plan Description. This applies to all eligible Participants.

While contributions are only made on your behalf while you are working for a contributing Employer, you don't have to be an active Participant to use your HRA. This means that as long as you, your spouse, or eligible dependents are self-paying COBRA or retiree coverage to continue coverage under the Plan, you may continue to use your HRA. In addition, your HRA balance is available to your surviving spouse and/or eligible dependents in the event of your death.

Continued Eligibility

Your eligibility for the HRA is based on your eligibility for Plan coverage. Once you are eligible, your eligibility continues on a quarter-to-quarter basis, provided the required contributions are made on your behalf and/or you make self-payments to continue coverage.

Under the HRA, you may continue to be reimbursed for eligible premiums you pay toward group health or long-term care insurance, as long as coverage continues under the Plan. However, premiums for individual market health coverage or health insurance plans purchased from a state or the federal Marketplace are not considered expenses eligible for reimbursement through the HRA.

Your HRA Balance During an Opt Out Period From Plan Coverage

If you opt out of the Plan's coverage because you have coverage available through a spouse's employer group plan, your HRA account will still be maintained for your use. As Employer contributions are received throughout a month, they will first be added your Administrative Account. Only at the end of each calendar quarter are excess dollars transferred to your HRA account.

If You Elect To Purchase Individual Insurance Coverage Through the State or Federal Marketplace

If you seek to purchase individual insurance coverage through the state or federal Marketplace Exchange, having an HRA account balance will affect your eligibility for government issued subsidies. Therefore, if you have an HRA account balance but wish to purchase individual

insurance coverage through the state or federal Marketplace Exchange, you are allowed to waive and forfeit all rights to future HRA reimbursements.

If you opt out of your HRA coverage and forfeit your account balance, and you later become eligible in the Plan again, you may begin accumulating new dollars in an HRA again. However, any HRA balance that you forfeited will not be restored.

When Eligibility Ends

As long as you are eligible for Plan coverage, you are eligible to use your HRA. Once your eligibility for Plan coverage ends, so too does your eligibility for the HRA.

If eligibility ends because of a COBRA qualifying event, you will be given the opportunity to continue the same coverage that you had the day before the qualifying event for the periods determined by COBRA (subject to all conditions and limitations of COBRA). This also applies to your HRA.

Once you lose eligibility for coverage for a 24-month period, any unused amount in your HRA will be forfeited. Any forfeited amounts revert to the Plan's general assets and are used for administrative expenses. In no event will forfeited amounts be paid to you or your dependents in cash.

Reimbursements After Eligibility Ends

When you are no longer eligible for coverage, and before your HRA is forfeited, you may submit expenses for eligible expenses that are incurred **before** your eligibility ended.

Life Events

- **Family and Medical Leave Act (FMLA).** During an FMLA leave, your HRA will be maintained if you properly notify your Employer of your leave and your Employer continues to make contributions on your behalf while you are on leave. The Fund will also maintain your eligibility until the end of the leave.

  Generally, an FMLA leave ends on the earlier of your return to work or after 12 weeks (or 26 weeks, if applicable). If you do not return to work within 12 weeks (or 26 weeks, if applicable) of the date your leave begins, you may be eligible for COBRA continuation coverage.

- **Military Leave.** If you enter the armed forces for less than 31 days, your HRA will be maintained if your Employer contributes on your behalf as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If your military service lasts 31 days or longer, you have two options:
  - You can continue your coverage by making self-payments or electing COBRA continuation coverage, at which time your HRA balance will be available for use; or
  - You can notify the Fund Office of your entry into the military, in writing, in which case your HRA balance will be frozen for the lesser of your length of service or five years. Your HRA balance will be available upon your reinstatement of eligibility for coverage, in accordance with the rules listed on pages 1 – 6 and 1 – 7.

- **Retirement.** If you retire and begin collecting a monthly pension from the Heat and Frost Insulators Local No. 33 Pension Fund, and you were previously maintaining active eligibility in the Plan, you can elect to continue coverage by having your account balance in your HRA applied to continue your eligibility. You could also elect to freeze your HRA to be used for other covered expenses. If you choose to freeze your HRA, and retired a monthly administrative fee of $50.00 per month will be charged to maintain your account. Your HRA

can continue to be applied to cover IRS approved expenses. If you are retired and Medicare-eligible, you can use the funds in your HRA to pay the premium for the Medicare Advantage program offered through the Heat and Frost Insulators Local No. 33 Health Fund.

- **In the Event of Your Death.** Your HRA balance will be available to your surviving spouse and/or eligible dependents after your death, and they can use the funds to pay for eligible expenses (including expenses you incurred before your death). They can also use the remaining funds to make self-payments to continue coverage under the Plan.

  While your surviving spouse and/or eligible dependents may continue to use your HRA as long as they are eligible to make self-payments for coverage, no further contributions will be transferred to the HRA. In addition, under no circumstances will the balance in your HRA be paid to your beneficiaries in cash.

If you have no surviving spouse and/or other eligible dependents at the time of your death, any balance in your HRA will be forfeited and become a part of the Plan's general assets.

BALANCE

Your HRA balance is the total of Employer contributions made on your behalf that are in excess of the balances necessary to maintain eligibility. Before the draw of $4,500 to maintain eligibility for a calendar quarter and $4,500 for the next quarter, Employer contributions accumulated in excess of $9,000 will be transferred into your HRA. Those contributions minus any reimbursements you request reflect your HRA account balance.

If money remains in your HRA at the end of a year, it rolls over into the next year.

Any unused amount in your HRA account are carried forward from calendar quarter to calendar quarter. Upon the termination of eligibility, unless you are retired, your HRA may be carried forward up to 12 consecutive months without forfeiture, unless retired and collecting a retirement benefit from the Local No. 33 Pension Plan. After retirement, your HRA balance will be carried forward until no balance remains or until you are no longer eligible for coverage.

Quarterly Statements

During the period you are eligible for benefits, you receive a quarterly statement report at the beginning of each calendar quarter (on or before April 1, July 1, October 1 or January 1), which will also identify your available HRA balance.

TAX STATUS AND CONSEQUENCES

Contributions credited to your HRA are pre-tax (not taxable income when made) and generally are not taxable when paid out as benefits.

If you submit an expense for reimbursement under the Plan's HRA, you cannot deduct that expense on your tax return.

The Fund makes no guarantee that any amounts paid for you, your spouse, or your eligible dependents under the HRA will be excludable from your gross income for federal, state, or local income tax purposes. It is your responsibility to determine whether payments under the HRA are excludable, and to notify the Fund if you have any reason to believe that such payment is not excludable.

If you receive reimbursement under the HRA on a tax-free basis, and the payment does not qualify for tax-free treatment under the Internal Revenue Code, you will be required to indemnify and reimburse the Fund for any liability incurred for failure to withhold federal income taxes, Social Security taxes, or other taxes.

ELIGIBLE HRA HEALTH CARE EXPENSES

As you incur eligible health care expenses, you can use the money in your HRA to pay for eligible expenses incurred by you, your spouse, and/or your eligible dependents. Eligible expenses, as defined by the Plan, include (but are not limited to):

- Coverage costs, including self-payment contributions or premiums:
  - To continue Plan coverage (this is an automatic transaction each calendar quarter, if necessary); and
  - Those that you and/or your spouse pay for other health or long term care insurance coverage (such as health insurance provided through your spouse's Employer, provided it is not paid on a pre-tax basis); and
- Health care expenses, including:
  - Out-of-pocket Plan costs, such as deductibles, copayments, and coinsurance; or
  - Qualified expenses not covered, or only partially covered, under the Plan.

In general, expenses eligible for reimbursement only include those that:

- Are incurred when you are eligible for Plan coverage and submitted for reimbursement within 15 months of the expense being incurred;
- You, your spouse, and/or your eligible dependents are required to pay;
- Are not reimbursed by insurance or any other source;
- You, your spouse, and/or your eligible dependents have not taken (or will not take) as a tax deduction; and
- Are tax-qualified medical care expenses under IRC Section 213(d). (See IRS Publication 502 for more information.)

Dependent Expenses

If your spouse and/or your other dependents meet the Plan's definition of dependent, you may submit their expenses for reimbursement from your HRA, even if they are not enrolled in the Plan. For example, if your spouse has other coverage and this Plan is not your spouse's primary plan, you may submit eligible expenses that your spouse incurs.

HRA Eligible Expenses

Expenses recognized by the Fund are eligible for reimbursement from your HRA if they are included as eligible expenses under Internal Revenue Code Section 105 and Section 213(d), unless otherwise listed in the Expenses Not Eligible for Reimbursement, Section 13. See IRS Publication 502 for further details. To be eligible for reimbursement, the expense must not be reimbursed from another source. A SAMPLE of expenses reimbursable includes, but is not limited to, the following:

- Contact lenses and solution.
- Copayments.
- Custom orthopedic devices.
- Dental charges.
- Eye examination fees.
- In-fertility treatment.
- Hearing exams, devices and batteries.
- Long-term care insurance premiums.

- Medications and medical supplies (e.g., syringes, needles, etc.).
- Oral surgery.
- Orthodontic fees.
- Payments for coverage, including self-payment contributions to continue coverage when you do not have sufficient contributions and COBRA continuation coverage self-payments.
- Pregnancy test kits.
- Prescription eyeglasses.
- Prescription medications from the United States.
- Special Education. Tuition and certain other expenses for children who have learning disabilities caused by mental or physical impairments.
- Transportation expenses that are primarily for, and essential to, medical care.
- Weight loss program if it is a treatment for a specific disease diagnosed by a Physician (such as obesity, hypertension, or heart disease). This does not include the cost of food or beverages.
- Wig purchased upon the advice of a Physician for a patient who has lost his or her hair from disease or treatment for a disease

In addition to the above, HRA eligible expenses also cover the following expenses that are not Covered Expenses under the Health Fund:

- Contributions a spouse is required to pay for Employer-sponsored group health coverage (provided the contributions are paid on an after-tax basis).
- Deductibles.
- Expenses applied to the out-of-pocket maximum.
- Eye surgery, including laser eye surgery (e.g., cataracts, LASIK, radial keratotomy, etc.).
- Smoking-cessation programs (but not amounts you pay for drugs that do not require a prescription, such as nicotine gum or patches).

EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

Expenses that are not eligible for reimbursement from the HRA include, but are not limited to, items that do not constitute "medical care," as defined in Internal Revenue Code §213d. Examples of such ineligible medical expenses include:

- Babysitting, childcare or nursing services for a normal, healthy child.
- Bottled water.
- Controlled substances (such as marijuana) that are in violation of federal laws (even if such substances are legalized by state law).
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, personal Injury resulting from an Accident or trauma, or disfiguring disease. Cosmetic surgery means any procedure that is directed at improving the patient's appearance and does not fully promote the proper function of the body or prevent or treat Illness or disease.
- Cosmetics, toiletries, toothpaste, etc.
- Custodial care.
- Dental bleaching.
- Diapers or diaper service.

- Diet foods or beverages.
- Disability insurance premiums.
- Expenses incurred before you are eligible to participate in the Plan.
- Funeral or burial expenses.
- Health club or fitness program dues.
- Household and domestic help.
- Life insurance premiums.
- Maternity clothes.
- Medicine and drugs from a country other than the United States.
- Nurse expenses to care for a healthy newborn at home.
- Over-the-counter items, drugs, medications (other than insulin or as otherwise provided under the Preventive Services benefit), or prescribed medications received outside the United States.
- Social activities (such as dance lessons).
- Teeth whitening.
- Uniforms or special clothing (such as maternity clothing).
- Weight loss programs for general health or appearance.
- Premiums for individual market coverage or insurance plans purchased from a state or federal marketplace.

Note that this list is subject to change based on the Internal Revenue Service'' definition of what is or is not an eligible expense for reimbursement.

CLAIMS AND REIMBURSEMENTS

You will only be reimbursed for eligible expenses up to the unused amount in your HRA. If you have any questions as to whether an expense is eligible for reimbursement, contact the Fund Office.

You must submit a claim for reimbursement of any eligible expense and back-up documentation in accordance with the procedures described in the *Filing and Processing a Claim* section. Reimbursement is paid directly to you; you are responsible for paying any providers.

Unfortunately, many HRA claims that are submitted to the Fund have to be returned to the claimants because they don't provide the necessary information. Here are a couple of tips to follow so that your HRA reimbursement is not delayed:

- Make sure your claim totals at least $25.
- Check and make sure that the item or service is an eligible expense.
- If you are submitting a large number of claims, submit one HRA claim form for each family member.
- Date and sign each claim form to comply with IRS regulations.
- Save your Explanation of Benefits (EOBs)—do not throw them away. You will need them if you want reimbursement of your coinsurance.
- Do not send balance due notices or statements from doctors or clinics—they will be returned to you.
- Do not expect a reimbursement if there are no funds in your HRA. You will not have more money in your account until more contributions are made on your behalf.

5. IN-NETWORK AND OUT-OF-NETWORK MEDICAL BENEFITS

You and your eligible dependents may obtain health care services from an in-network Anthem Blue Cross/Blue Shield (BC/BS) network provider or an out of-network health care provider. The following provisions will apply under the Plan.

Benefit Maximums

A number of specific benefits have maximum limitations. For example, chiropractic services are limited to a visit maximum per calendar year and physical therapy is subject to a maximum number of sessions per calendar year. These limits are applied on a combined basis for in-network and out-of-network services.

Calendar Year Maximum

This is the most the Plan will pay each calendar year for all Covered Charges for one person. It is unlimited. Generally, if you receive services or supplies from a BC/BS in-network provider, your out-of-pocket costs will be limited to a required copayment and/or deductible.

Lifetime Maximum Benefit

This is the most the Fund will pay for all Covered Charges for one person in a lifetime. It is unlimited.

Limitations and Exclusions

Certain medical expenses are not covered by the Plan at all. See Section 13, "*Medical Expenses Not Covered and General Plan Limitations and Exclusions*," for details about excluded expenses.

IN-NETWORK BENEFITS

Calendar Year Deductible

This is the amount you must pay each calendar year before the Fund pays medical benefits. The Plan's calendar year deductible per individual is $500.

Coinsurance

Once you have met your calendar year deductible, the Fund pays 80% of Covered Charges, and you (and not the Fund) are responsible for paying the rest. The part you pay (20%) is called your coinsurance.

Out-of-Pocket Calendar Year Maximum

The amount of out-of-pocket expenses you are responsible for paying each calendar year before the Fund pays 100% of most (but not necessarily all) of your in-network Covered Charges is $2,000 for an individual and $4,000 for a family.

Each calendar year, after you or one of your family members reaches the individual maximum out-of pocket cost of $2,000 (or your family reaches the $4,000 out-of-pocket family maximum), all in-network Covered Charges will be paid by the Fund at 100% during the remainder of the calendar year. This provision does not apply to Prescription Drug, Dental (which has its own

calendar year maximum benefit) or Vision Benefits. Individuals that have a severe Injury or ongoing Illness are financially protected from catastrophic out-of-pocket expenses provided they use in-network providers.

Expenses Not Subject to the Out-of-Pocket Maximum

There are expenses for medical services and supplies that you are always responsible for paying yourself. Under the Plan, each year you will be responsible for paying out of your own pocket:

- Your individual or family out-of-network deductible and coinsurance;
- All expenses for medical services or supplies that are not covered by the Fund;
- All charges in excess of the Reasonable and Customary charge for out-of-network medical and dental services, determined by the Fund; and
- All charges in excess of any other limitation of the Plan.

The Preferred Provider Organization

The Fund has contracted with Anthem Blue Cross/Blue Shield (BC/BS) to utilize their Preferred Provider Organization (PPO) network of hospitals, physicians, medical laboratories and other providers under a negotiated discounted fee arrangement. Covered persons who elect to utilize the PPO network's providers receive enhanced benefits in consideration of the Fund receiving negotiated discounted fees.

In many instances, when you use the services of an Anthem BC/BS in-network health care provider for any Medically Necessary services, you will only be responsible for paying the applicable copayment shown in the Schedule of Benefits. The copayment varies depending upon the type of care you receive. In addition, because the Fund has an agreement with the Anthem BC/BS PPO network, participating providers are prohibited from balance billing you for covered services in excess of their contractual discounted fee with the Fund.

To locate an Anthem BC/BS PPO in-network provider, you may use the online provider directory at www.anthem.com, or www.bcbs.com or call Blue Cross provider locator at the toll-free number 1-800-810-2583. Anthem BC/BS PPO in-network provider listings are furnished automatically, without charge, as a separate document.

No Copayment for Routine Physical Examinations and Related Laboratory Charges

There are no copayments for routine in-network physical examinations. In addition, there are no copayments for laboratory tests associated with a routine examination. You should have no out-of-pocket expenses for an in-network routine physical examination. See Section 6.7, item #40 of *Covered Medical Expenses*, for a complete list of Preventive Services benefits provided at no cost when obtained in-network.

Physician Office Visits and Laboratory and X-rays - $25 Copayment

You are only required to pay a $25 copayment for an office visit with a Physician participating in the Anthem BC/BS PPO network. The remaining cost of the charges covered will be paid for by the Fund. The $25 copayment applies to all services customarily performed in a Physician office setting.

Your $25 in-network Physician office visit copayment will accumulate towards your calendar year out-of-pocket maximum.

Surgery, anesthesia, laboratory services, and x-rays performed in a Hospital will be subject to the deductible and coinsurance for Outpatient Hospital Services.

You may be requested to pay the copayment at the time of your Physician office visit. An Anthem BC/BS in-network provider will submit claims directly. If, however, you utilize an out-of-network provider, it is your responsibility to submit a completed claim form before any reimbursement can be made to you or assigned directly to the provider.

Inpatient Hospital Admissions and Outpatient Hospital Services – Subject to Deductible and Coinsurance

If you are admitted on an inpatient basis to a Hospital participating in the Blue Cross/Blue Shield PPO network or your receive outpatient hospital services, the care you receive will be subject to the Plan's $500 calendar year deductible. You will also be responsible to pay 20% in coinsurance toward the billed charges. The Fund will pay the balance of all Covered Charges at 80% coinsurance until you reach your out-of-pocket maximum for the calendar year. Once you reach your out-of-pocket maximum, the Fund will pay the Covered Charges in full. This assumes all services while hospitalized are provided by network providers. **This coinsurance is applied to your annual maximum in-network out-of-pocket expense limit of $2,000 per individual or $4,000 per family per calendar year.**

If while hospitalized you are treated by a non-participating surgeon, anesthesiologist, radiologist, etc., the services and related charges of non-participating providers <u>are</u> subject to the out-of-network deductible and coinsurance requirements of the Plan.

For any Hospital stay, please refer to the Utilization Review Program requirements (Section 7).

Emergency Room - $200 Copayment (Applies In- and Out-of-Network)

If you seek treatment for a Medical Emergency from any Hospital, freestanding medical/urgent care facility, you will be responsible for a $200 copayment and the Fund will pay the remaining balance. Treatment that could be received from a general Physician are not medical emergencies. A "Medical Emergency" is the sudden and unexpected onset of a condition in which a delay in treatment would endanger your health or life. The diagnostic coding on the Emergency Room billing will determine if the charges were of a nature considered a "Medical Emergency". The following are considered medical emergencies by the Fund:

- Difficulty breathing.
- Severe burns.
- Broken bones.
- Unconsciousness.
- Excessive bleeding.
- Suspected heart attack.
- Acute and sudden pain.
- Shock.
- Any condition for which a Physician advises you to seek treatment in an emergency room.

The emergency room copayment will be waived if you are admitted to the Hospital, regardless of whether the emergency room services are provided in- or out-of-network.

OUT-OF-NETWORK BENEFITS

Generally, the Fund will not reimburse you for all out-of-network Covered Charges. You will have to satisfy a deductible and/or pay some coinsurance toward the amounts you incur that are Covered Charges.

Out-of-Network Deductible

The amount you must pay each calendar year before the Fund pays **out-of-network** medical benefits. The Plan's deductible is $500.

Coinsurance

Once you have met your calendar year deductible for out-of-network claims, the Fund pays 80% of Covered Charges, and you (and not the Fund) are responsible for paying the rest. The part you pay (that is 20%) is called your coinsurance.

Out-of-Pocket Calendar Year Maximum

There is no out-of-pocket calendar year maximum for services you receive from non-participating providers.

Out-of-Network Health Care Providers

Out-of-network health care providers have no contractual fee agreements with Anthem BC/BS and are generally free to set their own charges for the services or supplies they provide. The Fund will reimburse you for the Reasonable and Customary charge for any Medically Necessary services or supplies, which are Covered Charges, subject to the Fund's deductibles and coinsurance, along with the same limitations and exclusions set forth in Section 13. You must submit a claim before any reimbursement will be made, and out-of-network health care providers may bill you for any balance that may be due in addition to the amount payable by the Fund.

Reasonable and Customary Charges

Benefits paid by the Fund to out-of-network providers are subject to Reasonable and Customary limits. The use of this term may place a limit on the amount the Fund pays for the health care you receive. **If you utilize the services of a network provider or physician, the covered expenses are considered by the Fund and Reasonable and Customary will not apply to the charges.**

The **"Reasonable and Customary"** charge for Medically Necessary services or supplies will be determined by the Fund, or its designee, to be the usual charge by a health care provider for the same or similar service, surgical procedure, or supply for the geographic location where the provider practices, or the health care provider's actual charge.

The Fund will not pay more than the Reasonable and Customary charge for such benefit. The Reasonable and Customary charges may differ by area, so what is a Reasonable and Customary charge for a certain surgery in New Haven may differ from the Reasonable and Customary charge for the same surgery in Waterbury. For example, if your surgeon charges $4,000 for a certain surgery, and the Reasonable and Customary charge in your area is only $3,600, the Fund will consider and pay your claim on the basis of a $3,600 Reasonable and Customary charge only. You will be liable for the excess charges.

Before incurring medical expenses, check to determine if your doctor, surgeon or pediatrician is in the Anthem BC/BS network. You and the Fund will save money by utilizing network providers. If you utilize an out-of-network provider, ask about his charge for a particular procedure and if it exceeds the Reasonable and Customary allowance. Otherwise, you may be liable to pay part of the expense out of your own pocket.

6. COVERED MEDICAL EXPENSES

Medical expenses, whether received from an Anthem BC/BS network or from an out-of-network provider, are covered by the Fund to assist you and your eligible dependents in the payment of medical bills that result from serious or prolonged disabilities or ordinary Injuries and Illnesses. Refer to the *Schedule of Benefits* for coverage information.

Benefits are payable for the Medically Necessary charges incurred while you or your eligible dependent is covered under the Fund for treatment, services, and supplies ordered by a Physician. These include the following:

1. **Hospital expenses** incurred for inpatient treatment, except as otherwise indicated elsewhere in this booklet. Covered room and board charges may not exceed the Hospital's average rate for semiprivate rooms unless it is Medically Necessary to isolate the patient to prevent contagion as the result of any infectious disease. If a Hospital does not have semiprivate rooms, the Covered Charges will not exceed the average rate for such rooms charged by Hospitals located in the surrounding geographic area (for Hospital admissions, please refer to the requirements of Section 7, *Utilization Review Program*).
2. **Hospital** charges for **services and supplies** other than room and board charges incurred during an inpatient confinement.
3. Diagnosis, treatment, and **surgery** performed by a Physician.
4. The purchase or rental of **Durable Medical Equipment** such as wheelchairs and Hospital-type beds when accompanied by a prescription from a licensed qualified Physician. The Physician must also describe the Medical Necessity for the equipment and a cost comparison between the rental and purchase price of the equipment. The Fund will not pay for the purchase or rental of Durable Medical Equipment that is not approved by the Fund Office, regardless of the Medical Necessity. The Fund Office may require multiple quotes before authorizing Durable Medical Equipment as a covered expense. The benefit limit for renting such equipment will not exceed the purchase costs. The Fund will provide for the basic equipment required; the cost of any enhancements for personal or convenience reasons will be borne by you (i.e., the Covered Person). If the equipment has been purchased by the Fund, the Fund will own the equipment but has no responsibility for repair, upkeep or modification to the equipment.
5. **Services of a licensed, qualified Physician**, including a specialist for surgical and non-surgical care in a hospital, home, physician's office, or skilled nursing facility (for skilled nursing facility admissions, please refer to the requirements of Section 7, *Utilization Review Program*).
6. **Diagnostic x-rays, MRIs, CAT scans, and laboratory tests**.
7. Radium, radioactive isotopes, x-ray therapy, and **chemotherapy**.
8. **Anesthesia and its administration**, and inhalation therapy for treatment of a respiratory condition by inhalation of water vapors, oxygen, or other substances.
9. **Local ambulance service** (In or Out-of-Network) when used to transport you or your eligible dependents from the place where the Injury occurred or where the individual was stricken by an Illness to the nearest Hospital where treatment is rendered; and for local ambulance service from a Hospital to another Hospital, when the discharging Hospital has inadequate facilities for treatment and the receiving Hospital has appropriate treatment facilities.
10. **Blood**, including the cost of blood plasma and blood plasma expanders.

11. Prescription drugs, physical therapy, x-rays, and laboratory services rendered in a **skilled nursing** facility, provided that confinement begins within 14 days following a Hospital confinement of at least 3 consecutive days and both the Hospital and skilled nursing facility confinement are for the same Injury or Illness. **No other services or supplies, except those presented in the preceding sentence, will be covered when administered in a skilled nursing facility**.

12. **Drugs and medicines** while Hospital-confined, as well as those covered drugs and medicines prescribed by Physician.

13. Expenses incurred for care in an **after-hours urgent care center** or **walk-in center**, subject to a copayment.

14. Expenses incurred for care in a hospital **intensive care, critical care or neonatal intensive care unit**.

15. **Medical and surgical supplies**, such as oxygen (may require medical necessity approval; see Section 7), surgical dressing, and colostomy bags. Items ordinarily found in the home for general use, like adhesive bandages, petroleum jelly, and thermometers are not covered.

16. Charges made by a legally qualified Physician for treatment of **well baby care.** These periodic reviews include a medical history, complete Physician examination, developmental assessment, anticipatory guidance, immunizations, and laboratory tests. See "*Covered Preventive Services for Children*" later in this SPD, for more information about well baby care coverage.

17. Therapeutic treatment such as **chiropractic services** for, or in connection with, the correction by normal or mechanical means of structural imbalance or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is a result of or related to distortion, misalignment or subluxation, or in the vertebral column and not related to an Injury or disability arising out of or in connection with employment. **Such benefits will be payable to a maximum of 35 visits per calendar year**.

18. **Maternity charges**, for an Employee, spouse, or dependent daughter, including charges for Complications of Pregnancy and baby circumcision. The length of stay for a normal vaginal birth is 48 hours from the time of delivery and 96 hours for a cesarean birth unless both the mother and provider agree to a shorter stay.

19. Charges incurred for **diabetic supplies** (i.e., test strips, lancets and autoclix), as well as ostomy/colostomy supplies and insulin infusion pumps, when Medically Necessary and accompanied by a Physician's letter of Medical Necessity.

20. **Physical therapy** by a licensed Physician or physiotherapist, up to a combined maximum of 60 sessions in a calendar year (combined with occupational therapy and speech therapy; includes both in-network and out-of-network therapy).

21. **Occupational therapy** and/or **speech therapy** performed by a licensed provider, up to a combined maximum (with physical therapy) of 60 sessions in a calendar year (applies to both in-network and out-of-network therapy).

22. **Mammographic examinations** annually, or at the recommendation of a Physician.

23. Charges for services or treatment received in an **emergency room** for serious and sudden conditions, which are considered Medical Emergencies under the Fund, provided care is rendered within 72 hours of the onset of the Illness or Injury.

24. Charges recognized in accordance with the **Women's Health and Cancer Rights Act of 1998** including **reconstruction of the breast** on which a mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; breast prosthesis; surgical brassieres and treatment of physical complications of all stages of mastectomy including lymphedemas.

25. **Surgical assistance expenses** up to a maximum of 20% of the surgical allowance for charges made by a Physician for surgical assistance services given in connection with a covered Surgical Procedure. Surgical assistance services are the services of a Physician for necessary technical surgical assistance given to the operating Physician, while the Covered Person is confined in a Hospital as an inpatient and at the time when surgical assistance is not routinely available as a Hospital service.

26. Charges incurred for the use of a facility for **ambulatory (one-day) surgery** performed in Hospital operating rooms, outpatient surgical facilities in Hospitals, or freestanding surgical centers.

27. Charges for diagnosis and treatment of **infertility**, if prescribed by a Physician, provided such procedures are not Experimental. Benefits will be payable for the following:
    - Artificial insemination.
    - In-vitro fertilization and embryo placement.
    - Any cost associated with the attendant sperm, egg and/or inseminated egg procurement, processing and banking, to the extent such costs are not covered by the donor's insurer, if any, regardless of whether the donor is the insured's spouse.

28. Medical examination required by the **University of Connecticut Speech and Hearing Clinic** to dispense a hearing aid.

29. **Inoculations** including but not limited to Hepatitis, Pneumonia, Lyme Disease, Shingles, or any other Medically Necessary **preventive vaccines**.

30. **Allergy shots** when administered in a Physician's office and submitted with a diagnosis.

31. **Interferon shots** when administered in a Physician's office and submitted with a diagnosis.

32. **Stress tests** when submitted with a Physician's diagnosis.

33. **Sleep apnea tests** when submitted with a Physician's diagnosis stating Medical Necessity.

34. Annual **flu shots**.

35. **Home health care** expenses as a result of a non-occupational Illness or Injury, subject to deductible and coinsurance, up to a maximum of 60 sessions per calendar year. In order for benefits to be payable for the Reasonable and Customary charges made by a Home Health Care Agency, the following requirements must be satisfied:
    - You or your eligible dependent must be discharged from a Hospital from which the participating Home Health Care Agency has contracted to accept referrals, and you must receive prior approval from the Utilization Review Program (see Section 7) in advance of the services being provided; **and**
    - The home health services must enable you or your eligible dependents to be discharged from the Hospital earlier than would otherwise be possible, and such discharge must be recommended by the attending Physician; or
    - You or your eligible dependent must be essentially confined to home and physically or mentally incapable of obtaining Medically Necessary services and treatment on an outpatient basis ("homebound").

Benefits are payable for Reasonable and Customary charges made by a Home Health Care Agency for necessary services or supplies furnished to you or your eligible dependent in your home, in accordance with the Home Health Care Plan, for care which commences within seven (7) days following termination of a Hospital confinement as a resident inpatient and which is provided for the same or related condition for which you or your eligible dependent was Hospitalized:

- Part-time or intermittent nursing care by a registered graduate Nurse or by a licensed practical Nurse under the supervision of a registered graduate Nurse, if the services of a registered graduate Nurse are not available.
- Part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature, by other than a registered graduate or licensed practical Nurse. The home health aide must be an Employee of the Home Health Care Agency or working under supervision of a home health care professional.
- Physical therapy, occupational therapy, and speech therapy provided by the Home Health Care Agency.
- Medical supplies prescribed by a Physician and laboratory services by or on behalf of a Hospital, to the extent such items would have been covered as Medically Necessary if the individual had remained in the Hospital. Such supplies will be limited to a 30-day supply.
- Medical Social Services provided to or for the benefit of an individual diagnosed by a legally qualified Physician to be terminally ill, not to exceed a maximum amount of $200.
- Each visit by a member of a home health care team is considered one visit for the purposes of calendar year maximum. Four hours of home health care aide services are considered one visit. The services for medical supplies, drugs, etc., are payable as long as the 60 session benefit is still available.

In no event will Home Health Care Expenses include charges for:

- Services or supplies furnished to an individual eligible for Medicare.
- Services such as elastic stockings, sheepskin, lotions, mouthwash, or body powder.
- Housekeeping services.
- Custodial Care.
- Services of a person who ordinarily resides in the individual's home or is a member of the family of either the Participant or the Participant 's eligible dependent spouse.
- Any period during which you or your eligible dependent is not under the care of a Physician.

If a Covered Person is eligible for Home Health Care coverage under more than one policy or contract, the Home Health Care benefits will only be provided by the policy or contract that would have provided the greatest benefits for Hospitalization, if such individual had remained Hospitalized.

36. **Hospice care** if, while insured, such person submits a statement to the Fund Office from a hospice Physician attesting to the fact that he is terminally ill with six (6) months or less to live. Such statement must be submitted to the Fund Office within two (2) weeks prior to receiving any hospice care. Coverage includes both medical and non-medical treatment, when received in a licensed hospice program. Covered Charges of Hospice Care are subject to limitations and restrictions set forth in the Plan. Included in these limitations is coverage

for bereavement counseling services by a licensed social worker or licensed minister for the patient's immediate family-tip to a maximum of $200 and furnished within 6 months after the patient's death.

37. **Pre-admission testing** on an outpatient basis, prior to a Hospital admission and ordered by a Physician, provided:

    - The tests are related to the scheduled surgery or Hospital admission.
    - The tests are performed in the Hospital where the confinement or surgery will occur and accepted by the Hospital, in lieu of the same tests made after confinement.
    - The person does not cancel the scheduled surgery or Hospital confinement, unless for reasons beyond the control of the Physician, Hospital, or such person. Other qualifications are set forth in the Plan.

38. Charges for a routine **annual physical examination** for adults (for this benefit, covered individuals age 22 and older) by a legally qualified Physician for one (1) medical examination per calendar year. This includes related charges incurred for immunizations. (See "Preventive Services" item # 40 below, for a more complete description of this benefit.)

39. Charges for treatment of **mental and nervous disorders** or treatment of **alcoholism and/or substance use disorder**.

40. Charges due to participation in an **Approved Clinical Trial**

    The Plan will cover charges incurred due to participation in either a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, provided the charges are:

    - Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Plan if the individual were not participating in the Approved Clinical Trial; and
    - Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

    A Participant or dependent is eligible for payment of charges related to participation in an Approved Clinical Trial if he or she:

    - Satisfies the protocol prescribed by the Approved Clinical Trial provider; and
    - Either:

        (i) The individual's network participating provider determines that the individual's participation in the Approved Clinical Trial would be medically appropriate; or

        (ii) The individual provides the Plan with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

An Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Approved Clinical Trial's study or investigation must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA); (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services (HHS) determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Excluded expenses include:

- Expenses incurred due to participation in an Approved Clinical Trial that are: (1) the investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial; (2) items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
- Expenses incurred at a non-network provider if a network participating provider will accept the patient in an Approved Clinical Trial.

41. **Preventive services** are covered as required by the Affordable Care Act (ACA). (See Section 13 for the Plan's limitations and exclusions on these services.)

If coverage is provided ***in-network***, there is no cost sharing (for example, no deductibles, coinsurance or copayments) for the following preventive services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations;
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC); and
- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines and HRSA guidelines relating to services for women.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In such a case, the Trustees will determine whether a particular benefit is covered under this preventive services benefit.

The following benefits are available under the Plan's preventive services benefit with no cost sharing. In certain circumstances, as determined by the Plan, the preventive benefit is only payable with an appropriate diagnosis.

Non-preventive services are not covered without cost sharing. The Plan will impose cost sharing for treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

Covered Preventive Services for Adults

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked;
- Alcohol misuse screening and counseling: Screening and behavioral counseling interventions to reduce alcohol misuse by adults ages 18 and older, including pregnant women, in primary care settings;
- Aspirin use for men ages 45 to 79 and women ages 55 to 79 when prescribed by a health care provider to prevent cardiovascular disease. A prescription must be submitted in accordance with Plan rules;
- Blood pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit;
- Cholesterol screening for men aged 35 and older and women aged 45 and older, men aged 20-35 if they are at increased risk for coronary heart disease, and women aged 20 to 45 if they are at increased risk for coronary heart disease;
- Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient. The Plan will not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure;
- Depression screening for adults;
- Type 2 diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg;
- Diet counseling for adults at higher risk for chronic disease;
- HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk;
- Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Screening includes measurement of BMI by the clinician with the purpose of assessing and addressing body weight in the clinical setting;
- Sexually transmitted Infection (STI) prevention counseling for adults at higher risk;
- Tobacco use screening for all adults and cessation interventions for tobacco users;
- Syphilis screening for all adults at higher risk;
- Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
- Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls; and
- Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. A prescription must be submitted in accordance with Plan rules.

Covered Preventive Services for Women, Including Pregnant Women

- Well woman office visits for women ages 21 to 64, for the delivery of required preventive services;
- Anemia screening on a routine basis for pregnant women;
- Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later;
- BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will also cover BRCA 1 or 2 genetic tests without cost-sharing, if appropriate as determined by the woman's health care provider;
- Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every 1 to 2 years for women aged 40 and older.
- Breast cancer chemoprevention counseling for women at higher risk. The Plan will pay for counseling by physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention;
- Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment. The Plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the Plan;
- Cervical cancer screening for women ages 21 to 65 with Pap smear every three years;
- Human papillomavirus testing for women ages 30 and older with normal Pap smear results, once every three years as part of a well woman visit;
- Chlamydia infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, chlamydia infection screening is covered as part of the prenatal visit;
- For women of reproductive capacity, the Plan will cover at least one form of contraception in each of the FDA-approved contraceptive methods (including barrier and hormonal methods and implanted devices) as well as patient education and counseling, when prescribed by a health care provider.

  The FDA-approved contraception methods for women include:

  (i) Sterilization surgery
  (ii) Surgical sterilization implant for women
  (iii) Implantable rod
  (iv) Intrauterine device (IUD) copper
  (v) IUD with progestin
  (vi) Shot/injection
  (vii) Oral contraceptives (combined pill)
  (viii) Oral contraceptives (progestin pill)

(ix) Oral contraceptives (extended/continuous use)

(x) Patch

(xi) Vaginal contraceptive ring

(xii) Diaphragm

(xiii) Sponge

(xiv) Cervical cap

(xv) Female condom

(xvi) Spermicide

(xvii) Emergency Contraception (Plan B/Plan B One Step/Next Choice)

(xviii) Emergency Contraception (Ella)

- The Plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The Plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing;
- Folic acid supplements for women are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid. A prescription must be submitted in accordance with Plan rules;
- Gonorrhea screening for all sexually active women, including those who are pregnant, if they are at increased risk for infection (i.e., young or have other individual or population risk factors), provided as part of a well woman visit. The Plan will pay for the most cost-effective test methodology only;
- Counseling for sexually transmitted infections, once per year as part of a well woman visit;
- Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known;
- Hepatitis B screening for pregnant women at their first prenatal visit;
- Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Younger women will be eligible for screening if their risk of fracture is equal to or greater than that of a 65-year-old woman. The Plan will pay for the most cost-effective test methodology only;
- Rh incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative;
- Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes;
- Tobacco use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users;
- Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit; and
- Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.

Covered Preventive Services for Children

- Well baby and well child visits from age newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will include the following age-appropriate screenings and assessments:
  - (i) Developmental screening for children under age 3, and surveillance throughout childhood;
  - (ii) Behavioral assessments for children of all ages;
  - (iii) Medical history;
  - (iv) Blood pressure screening;
  - (v) Depression screening for adolescents ages 11 and older;
  - (vi) Vision screening;
  - (vii) Hearing screening;
  - (viii) Height, weight and body mass index measurements for children;
  - (ix) Autism screening for children at 18 and 24 months;
  - (x) Alcohol and drug use assessments for adolescents;
  - (xi) Critical congenital heart defect screening in newborns;
  - (xii) Hematocrit or Hemoglobin screening for children;
  - (xiii) Lead screening for children at risk of exposure;
  - (xiv) Tuberculin testing for children at higher risk of tuberculosis;
  - (xv) Dyslipidemia screening for children at higher risk of lipid disorders;
  - (xvi) Sexually transmitted infection (STI) screening and counseling for sexually active adolescents;
  - (xvii) Cervical dysplasia screening at age 21; and
  - (xviii) Oral health risk assessment;
- Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns);
- Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea;
- Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. A prescription must be submitted in accordance with Plan rules;
- Iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. A prescription must be submitted in accordance with Plan rules;
- Obesity screening for children aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status;
- HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection; and

- Counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

Immunizations

Routine adult immunizations are covered for Participants and dependents who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.

- Immunization vaccines for adults—doses, recommended ages, and recommended populations must be satisfied:
  - (i) Diphtheria/tetanus/pertussis;
  - (ii) Measles/mumps/rubella;
  - (iii) Influenza;
  - (iv) Human papillomavirus (HPV);
  - (v) Pneumococcal (polysaccharide);
  - (vi) Zoster;
  - (vii) Hepatitis A;
  - (viii) Hepatitis B;
  - (ix) Meningococcal; and
  - (x) Varicella.
- Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations must be satisfied:
  - (i) Hepatitis B;
  - (ii) Rotavirus;
  - (iii) Diphtheria/tetanus/pertussis;
  - (iv) Haemophilus influenzae type b;
  - (v) Pneumococcal;
  - (vi) Inactivated Poliovirus;
  - (vii) Influenza;
  - (viii) Measles/mumps/rubella;
  - (ix) Varicella;
  - (x) Hepatitis A;
  - (xi) Meningococcal; and
  - (xii) Human papillomavirus (HPV).

Office Visit Coverage

Preventive services are paid based on the Plan's payment schedules for the individual services. However, there are situations in which an office visit may not be payable under the preventive services benefit. If the primary purpose of the office visit is not for a preventive item or service, then the Plan will impose cost sharing with respect to the office visit. For example, if an individual schedules an in-network office visit to discuss recurring abdominal pain, and during the office visit the individual has a blood pressure screening, the office visit will be covered subject to the Plan's cost sharing requirements, e.g. the deductible, if not already satisfied, and coinsurance, because the blood pressure screening was provided as part of an office visit, for which the primary purpose was not to deliver recommended preventive items or services.

Well child annual physical exams recommended in the Bright Futures Recommendations (for children from birth through age 21) are treated as preventive services and paid at 100%.

Out-of-network covered preventive services are subject to the out-of-network deductible and coinsurance.

7. UTILIZATION REVIEW PROGRAM

The Fund retains the services of Hines & Associates to administer its Utilization Review Program. All proposed scheduled non-emergency Hospitalizations and outpatient surgeries must be reviewed before you or your eligible dependent(s) are admitted to a Hospital or have the surgery performed for the services to be covered by the Fund without being subject to a penalty. Review of your non-emergency Hospitalization or surgery may be obtained by calling Hines & Associates 24 hours a day, any day, at 1-800-944-9401.

IMPORTANT - THE FOLLOWING TREATMENT OR SERVICES MUST BE PRE-CERTIFIED WITH HINES & ASSOCIATES BEFORE THE PLAN WILL COVER THESE CHARGES:

- Inpatient Hospital admission for medical treatment
- Surgery, both inpatient and outpatient
- Inpatient treatment for mental health
- Inpatient treatment for alcohol and substance use disorder
- Home Health care
- Hospice care

Hines & Associates administers the Fund's Utilization Review Program, which is designed to work with you and your Physician to keep medical care costs as low as possible, consistent with good medical care. In many instances, review of the need for Hospitalization and exploration of available alternatives will indicate that admission to the Hospital may be avoided and quality treatment may be better provided in a less restrictive environment. This program is part of your Fund to help you use alternatives effectively so you can avoid the inconvenience of a Hospital stay entirely, or spend some of your time recovering in a less restrictive setting, perhaps even in your own home. To achieve the best results, follow the steps described in this section for non-emergency medical care. These procedures are in your best interest, **whether or not this Fund is primarily or secondarily liable for such care.**

ALL TREATMENT DECISIONS REST WITH YOU AND YOUR PHYSICIAN (OR OTHER HEALTH CARE PROVIDER). YOU SHOULD FOLLOW WHATEVER COURSE OF TREATMENT YOU AND PHYSICIAN (OR OTHER HEALTH CARE PROVIDER) BELIEVE TO BE THE MOST APPROPRIATE, EVEN IF: (1) A PROPOSED SURGERY OR TREATMENT IS NOT CERTIFIED AS MEDICALLY NECESSARY; OR (2) THE PLAN WILL NOT PAY REGULAR PLAN BENEFITS FOR A HOSPITALIZATION.

With respect to the administration of this Plan, your Employer, the Board of Trustees and the Plan are **not** engaged in the practice of medicine, and do not take responsibility either for the quality of health care services actually provided or for the results if the patient chooses not to receive health care services that have not been certified by the Utilization Management Program. With regard to Utilization Management, you should keep in mind the following:

- Not all services proposed or provided by a treating Physician will be considered Medically Necessary.
- Certification of Medical Necessity does not necessarily mean that you or your eligible dependents are eligible or that benefits will be payable.
- Patients should follow whatever treatment is most appropriate, but payment of benefits may be affected by the determination of the Utilization Management Program.

- You have the right to appeal all adverse determinations made by Hines & Associates (please refer to Section 20 of this booklet).

Non-Emergency Cases

If your Physician recommends that you or your eligible dependent be admitted to a Hospital on a non-emergency basis for day treatment, including outpatient surgery, show the Physician your health benefit identification card. You or your eligible dependent must contact Hines & Associates at the number on your ID card to obtain a pre-admission authorization. Your Physician may also provide the information necessary for the pre-admission approval by calling Hines & Associates directly.

Federal law prohibits the restriction of benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section.

The professional staff at Hines & Associates will review the clinical information submitted by your Physician and, if Medically Necessary, approve the **Hospital admission or surgery**. If an inpatient Hospital stay is necessary, Hines & Associates will advise your Physician of the recommended length of the Hospital stay. Hines & Associates' staff will work with your Physician throughout your confinement to assure that your continuing care needs are effectively met. For certain outpatient surgeries, a professional at Hines & Associates may require certain criteria be met before approving the surgery or may require a second surgical opinion before approving the surgery.

Emergency Cases

In the event you or your eligible dependent is confined to a Hospital on an emergency admission basis, you, a responsible family member, the attending Physician or the Hospital must call Hines & Associates **no later than 48 hours after admission** or (if a weekend admission or holiday) the next business day at the toll-free number on your ID card, notifying an Hines & Associates representative of the confinement and providing the information required to establish pre-certification of a Hospital admission.

Emergency Hospitalization means a confinement required as the result of an unforeseen medical, mental health or substance use disorder situation that requires immediate medical, mental health or substance use disorder treatment to prevent loss of life or permanent damage to the organs or systems of the body. A Hospital admission or surgery made or performed for the convenience of a patient or Physician is not a medical emergency.

Concurrent Review

Once you are in the Hospital, your case will be reviewed continually. This assessment is called concurrent review. Hines & Associates will perform a regular review of your medical progress in consultation with your Physician and Hospital staff. The purpose of concurrent review is to monitor the necessity of continued Hospitalization and to ensure that you will receive the needed care or services after your discharge from the Hospital. If you require continued medical care, but not intensive services of a Hospital, Hines & Associates will work with you, your Physician and the Hospital staff to develop a discharge plan that allows an early and safe release from the Hospital.

Extension of Time

If the initially approved Hospital days have been used and you or your eligible dependent remain confined, you or your Physician or Hospital staff must call Hines & Associates to obtain authorization for additional time required in the Hospital. If Hines & Associates' professional staff agrees that continued confinement is Medically Necessary, additional days will be approved.

Large Case Management

Hines & Associates will also provide a special service designed to assist patients with serious Illnesses or injuries involving prolonged confinements or expensive treatments. Many people who have used this kind of service have found that it provides valuable assistance and peace of mind during difficult periods or serious Illness. Serious medical cases include:

- Chronic Illnesses requiring Home Health Care.
- Acute catastrophic Injury.
- Infectious diseases.
- Burns.
- Terminal Illnesses.
- Neonatal complications.

A case management coordinator from Hines & Associates will contact you and your family to discuss medical care needs. Your personal case management coordinator will help you by:

- Facilitating communication among the professionals involved in your treatment plan.
- Providing information about your treatment and coverage options.
- Identifying any additional medical resources that may be available to you.

You are encouraged to take advantage of this valuable case management service.

8. TREATMENT OF MENTAL AND NERVOUS DISORDERS AND ALCOHOL AND SUBSTANCE USE DISORDER

Inpatient Treatment Benefit

If you or your eligible dependents incur covered medical charges for a mental and nervous disorder or for alcohol and substance use disorder as an inpatient in a network Hospital or approved facility, in order for the charges to be covered, the confinement must be recommended by a Physician as being Medically Necessary and approved by Hines & Associates (refer to Section 7).

Covered Charges will include the charges for treatment recognized by the medical profession as appropriate methods for the treatment of mental and nervous disorders, alcohol, and/or substance use disorder, in accordance with broadly accepted standards of medical practice, taking into account the current condition of the individual. If private accommodations in a facility are used, covered medical expenses will not exceed the facility's average daily rate for semi-private accommodations.

Effective Treatment of Alcoholism

Effective treatment of alcoholism is a program of alcoholism therapy that meets both the following tests:

- It is prescribed and supervised by a Physician who certifies that a follow-up plan has been established which includes therapy by a Physician or group therapy under a Physician's direction, at least once a month.
- It includes attendance at least twice a month at meetings of organizations devoted to the therapeutic treatment of alcoholism.

Treatment solely for detoxification or primarily for maintenance care is not considered effective treatment and will not be covered under this Plan. However, benefits will be payable for detoxification and/or maintenance, if appropriate treatment is received within 7 days immediately following detoxification and/or maintenance care. Detoxification is care aimed primarily at overcoming the aftereffects of a specific drinking episode. Maintenance care consists of providing a sheltered environment without access to alcohol.

Effective Treatment of Substance Use Disorder or Drug Addiction

Effective treatment of substance use disorder or drug addiction includes diagnostic evaluation, medical, psychiatric and psychological care, counseling, and rehabilitation when prescribed and supervised by a Physician for incapacitation by, or physiological or psychological dependence on, drugs.

Definition of an Alcoholism or Drug/Substance Use Disorder Treatment Facility

When applied to the treatment of alcoholism, a treatment facility is an institution (or distinct part thereof) which meets fully all of the following tests:

- It is primarily engaged in providing, for compensation from its patients and on a full-time basis, a program for diagnosis, evaluation and treatment of alcoholism.
- It provides, or has a formal agreement with a Hospital in the area to provide emergency care services, including, but not limited to, detoxification and medical treatment services continuously on a 24-hour basis.

- It is under the continuous supervision of a staff of Physicians on a 24-hour basis, and it continuously provides Skilled Nursing Services on a 24-hour basis under the direction of a full-time registered graduate Nurse, with licensed nursing personnel on duty at all times.
- It provides, or has a formal agreement with a Hospital in the area to provide diagnostic x-ray, laboratory and pharmaceutical services.
- It prepares and maintains a written plan for admission, care, treatment, and discharge for each patient. The plan must be based on the diagnostic assessment of the patient's medical, psychological and social needs with documentation that the plan is under the direction of a Physician.
- It meets any applicable licensing standards established by the jurisdiction in which it is located.

9. PRESCRIPTION DRUG BENEFITS

The Fund has contracted with OptumRx to administer its Prescription Drug Benefit. You must use a participating OptumRx Pharmacy or the OptumRx mail order program to receive this benefit. **This means there is no coverage for prescription drugs when obtained out-of-network.**

AT A RETAIL PHARMACY

1. There is no annual maximum benefit (unlimited).
2. There is a $10 copayment per prescription for generic drugs.
3. There is a $30 copayment per prescription for preferred brand name drugs.
4. There is a $50 copayment per prescription for non-preferred brand name drugs.

The maximum monthly supply of a prescription at a retail Pharmacy that can be dispensed is a 30-day supply.

THROUGH THE MAIL ORDER PROGRAM

1. There is a $20 copayment per prescription for generic drugs.
2. There is a $60 copayment per prescription for preferred brand name drugs.
3. There is a $100 copayment per prescription for non-preferred brand name drugs.

The quantity dispensed by the mail order Pharmacy is a 90-day supply.

The generic equivalent of all prescriptions will be dispensed, unless no generic equivalent exists or your Physician strictly prescribes the brand name drug.

A separate Out-of-Pocket Calendar Year Maximum will apply to prescription drug copayments of $1,000 for an individual and $2,000 for a family.

Your Fund prescription drug identification card is required to access this benefit. You must present your OptumRx identification card to a local retail Pharmacy when filling your prescription or refills of an existing prescription. New Participants will receive identification cards shortly after becoming eligible.

In order to use your prescription card, simply go to any participating Pharmacy, present your identification card to the pharmacist, and pay the applicable copayment. The remainder of the charge will be billed directly to and paid by the Fund. Your copayment is not reimbursable by the Fund. In addition, copayments are not applied to your out-of-pocket maximum and are not applied in coordinating benefits with other insurance programs.

To locate a network Pharmacy in and/or outside of Connecticut, call OptumRx Customer Service directly at the phone number on your ID card. Additional information about OptumRx can also be obtained on its website, www.optumrx.com. If your pharmacist has a question, they can call OptumRx at 1-800-788-7871.

NOTE: *If you obtain prescription drugs through a non-participating Pharmacy or do not present your identification card at the time of purchase, you will not be reimbursed by the Fund for any part of that prescription drug purchase. You will be responsible for the full payment.*

This Prescription Drug Benefit is not intended to pay for, nor will it reimburse you or your eligible dependents for, the prescription copayments of another plan you may be covered under.

COVERED PRESCRIPTION DRUGS

Payment will be made for the following drugs obtained by yourself or an enrolled eligible dependent through a participating Pharmacy upon presentation of your valid Fund identification card:

1. All drugs bearing the legend "Caution: Federal law prohibits dispensing without a prescription" and drugs requiring a prescription under applicable state law.
2. Prescribed injectable insulin, including syringes for diabetics, diabetic supplies (blood/urine tests).
3. Compounded medications of which at least one ingredient is a Federal legend drug.
4. Prescribed smoking cessation products and infertility medications (not over-the-counter items).

Prescriptions are dispensed subject to a maximum of a 30-day supply when purchased at retail or a 90-day supply when the prescription is a maintenance medication and/or purchased through mail order.

Maintenance/Mail Order Prescription Drugs

If you are on maintenance prescription drugs, you will save money if you use the Mail Order Prescription Program. At a retail Pharmacy, you can only receive a 30-day supply. However, the Mail Order Prescription Program allows you to receive a 90-day supply.

The use of the OptumRx's Mail Service Pharmacy eliminates frequent trips to the Pharmacy and is less expensive for you if you are taking a maintenance drug. You can order prescriptions in advance either by mail, online or by calling OptumRx using the information shown on your ID card. Mail order prescriptions are usually filled within 10 business days and delivered to your home. Refills of mail order prescriptions are usually filled within seven business days. Your prescription will be sent to you First Class mail or UPS. Note that instructions for refilling your prescription will be included with your first order.

If your medication must be taken without delay, fill your prescription immediately at a participating Pharmacy. If your prescription is for an extended period of time, ask your doctor for a second prescription that can be sent to the OptumRx Mail Service Pharmacy so you can also submit your prescription to the mail order program to obtain refills through the mail order program.

If you have any questions or concerns, you or your eligible dependents should call the Fund Office at 1-800-446-8646 or OptumRx at the number on your ID card.

Your Physician can contact OptumRx directly to arrange for your maintenance prescription. Please have your Physician contact the Fund Office to obtain the information necessary to make these arrangements.

Limitations and Exclusions

No payment will be made for:

1. Any non-legend drugs other than insulin.
2. Any drugs, vitamins (other than as provided for under the Preventive Services benefit), diet supplements, anorexiants, etc., whether or not prescribed by a Physician, unless deemed Medically Necessary and prior authorization is received from OptumRx.
3. Any weight loss medication or supplements, unless deemed Medically Necessary and prior authorization is received from OptumRx.

4. Smoking cessation products that do **not** require a prescription.
5. Fertility medications **not** prescribed by a Physician.
6. Growth hormones and anabolic steroids, unless deemed Medically Necessary and prior authorization is received from OptumRx.
7. Investigational or experimental drugs (compounded medications for non-FDA approved use) and the prescription must be FDA approved for the treatment of the specific diagnosis, unless prescribed as a result of participating in an Approved Clinical Trial.
8. Drugs intended for use in a Physician's office or another setting other than home use.
9. Therapeutic devices or appliances or support garments.
10. Prescriptions for animals.
11. Drugs payable under any Workers' Compensation Law.
12. Drugs, which an eligible person is entitled to receive without charges under local, state, or federal programs.
13. Drugs dispensed during confinement in a Hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent facility, nursing home, or similar institution, which operates on its premises a facility for dispensing pharmaceuticals.
14. Immunological agents.
15. Over-the-counter medications (other than insulin or as otherwise provided for under the Preventive Services benefit).
16. Any medication used strictly for cosmetic purposes.
17. Charges for injection or administration of drugs.
18. Drugs not received from a licensed Pharmacy.
19. Certain medications including but not limited to those like Imitrex and Ritalin, require a medical diagnosis and prior authorization of medical necessity by OptumRx.
20. Methadone treatments; unless prescribed for pain relief and prior authorization is received from OptumRx.
21. Services for which benefits are not payable according to the "Plan Limitations and Exclusions" Section 13.

10. DENTAL AND ORTHODONTIC BENEFITS

The Fund has entered into an arrangement with Delta Dental Plan of New Jersey, Inc. (called "Delta Dental") to provide access to Delta Dental participating Dentists, process dental benefit claims and provide certain other services under the Plan.

Delta does not insure the dental benefits described in this booklet. These dental benefits are self-insured by the Heat and Frost Insulators Local No. 33 Health Fund. Also, oral surgery is not an expense administered by Delta Dental, those expenses are considered medical and oral surgery claims should be submitted to Insurance Programmers, Inc.

HOW TO USE THE PROGRAM

Before visiting a Dentist, check to see whether the Dentist participates in Delta Dental's network.

At the time of your first appointment, tell your Dentist that you are covered under the Delta Dental program. Show him/her your ID card (showing the Plan's group name and group number), as well as your Social Security card. Your dependents, if covered, also must give your Social Security number.

After your Dentist performs an examination, he or she may submit a Pre-Treatment Estimate of benefits to Delta Dental to determine how much of the charge will be your responsibility. Before treatment is started, be sure you discuss with your Dentist the total amount of his/her fee. Although Pre-Treatment Estimates are not required, Delta Dental strongly recommends you ask your Dentist to submit a Pre-Treatment Estimate for treatment costing $300 or more. This is especially important when using a non-participating Dentist because the Pre-Treatment Estimate lets you know in advance how much of the costs are your responsibility. Please keep in mind that Pre-Treatment Estimates are only estimates and not a guarantee of payment.

WHY SELECT A NETWORK DENTIST?

All Delta Dental participating Dentists have agreed, in writing, to abide by Delta Dental's claims processing procedures.

- Participating Dentists have agreed to accept the lesser of their actual charge, their pre-filed fee, or Delta Dental's maximum allowable fee for the program as payment in full and not to charge patients for amounts in excess of those indicated in the "patient payment" portion of the Notification of Delta Dental Benefits.
- Participating Dentists will usually maintain a supply of claim forms (also referred to as Attending Dentist's Statements) in their office. You may be asked to complete a portion of the form when you visit.
- Participating Dentists will complete the rest of the form, including a description of the services that were performed or will be performed in the case of a Pre-Treatment Estimate, and require that you sign the claim form in the appropriate place. For Dentists who submit claims electronically to Delta Dental, you will need to authorize your Dentist to maintain your signature on file.
- Participating Dentists will mail, fax, or electronically submit the claim form, together with the appropriate diagnostic materials, directly to our offices for processing.
- Participating Dentists agree to abide by Delta Dental processing policies. For example, participating Dentists agree not to bill separate charges for infection control measures. Nonparticipating Dentists are not bound by such policies.

- Participating Dentists will, in the case of dental services that have been completed, receive payment directly from Delta Dental for that portion of the treatment plan that is covered by the Plan. You will receive a Notification of Delta Dental Benefits with a detailed description of covered benefits and the amount of your obligation.
- If you visit a non-participating Dentist, you will be responsible for payment. Delta Dental will reimburse you for the portion of your services covered by your program.

We advise that you check with your Dentist to confirm whether s/he participates in the Delta Dental program. While a Dentist may participate with Delta Dental, s/he may not participate in all of the programs.

LOCATING A DENTIST

Delta Dental offers two easy ways to locate a participating Dentist 24 hours a day, 7 days a week. You can either:

- Call l-800-DELTA-OK (1-800-335-8265); or
- Search the Internet at www.deltadentalnj.com

By calling the toll-free number, you can obtain a customized list of participating Dentists within the geographic area of your request. Delta Dental mails the list to your home.

By searching on the Internet, you can obtain a list of participating Dentists in a specific town. The list can be downloaded immediately, and you can search for as many towns as needed.

Using either method, you can request a list of Delta Dental participating Dentists within a designated area. You can specify listings of general Dentists only or specialists only. Participating Dentist information can be obtained for Dentists nationwide.

DENTAL COVERED SERVICES

Preventive & Diagnostic Services (No Deductible)—Plan Pays 100%

- Exams, Cleanings, (each twice per calendar year per person, ages 14 and older are considered adults for this benefit).
- X-rays-full mouth series or panoramic (either one, once in two years).
- X-rays-bitewing (twice per calendar year).
- X-rays-single films (multiplex-rays on the same date of service will not exceed the benefit of a full-mouth series).
- Fluoride Treatment (twice per calendar year, for eligible children to age 19, combinations with cleanings are applied to time limits for both).
- Space Maintainers (once per space for missing posterior primary teeth, for children under age 14).
- Sealants (1^{st} and 2^{nd} permanent, decay-free molars, once in a lifetime per tooth, for children to age 19).

Remaining Basic (No Deductible)—Plan pays 80%

- Consultations (payable once per specialty in a calendar year but may reduce the approved charge for the final treatment rendered by the same Dentist).
- Fillings—composite and amalgam (composite fillings on back teeth are given the alternate benefit of an amalgam filling, payable once per year for decay or fracture only).
- Extractions, Oral Surgery (impacted wisdom teeth claims should first go to medical carrier).
- Endodontics (root canals on permanent teeth and root surgery each once per 24 months).
- Periodontics (have specific frequency limitations, pre-treatment estimate is strongly recommended, e.g., surgery once per 36 months).

Prosthodontics & Crowns (No Deductible)—Plan pays 50%

- Crowns and crown-related procedures (post and core, core buildup, etc., once every five years, permanent teeth only, for ages 12 and older).
- Bridgework (once every five years, for ages 16 and older) (bridges with four or more missing teeth in that arch may be given an alternate benefit of a partial denture).
- Full & Partial Dentures (either one, once every five years, partial dentures for ages 16 and older) (fixed bridges and removable partial dentures are not benefits in the same arch; benefits will be provided for the removable partial denture only).
- Inlays (inlays are only payable when done in conjunction with an onlay; by themselves they are given the alternate benefit of an amalgam filling).
- Repair of Dentures (repair of existing prosthetic appliances).

Oral surgery is not an expense administered by Delta Dental, those expenses are considered medical and oral surgery claims should be submitted to Insurance Programmers, Inc. and processed subject to the Medical plan provisions.

Calendar Year Maximum: $1,000 (does not apply to covered individuals under age 19)

Non-participating Dentists may balance bill above the maximum allowable.

ORTHODONTIC BENEFIT

For Eligible Dependent Children through Age 26

The Orthodontic Expense Benefit pays 50% of Reasonable and Customary for a correctable major malocclusion that significantly interferes with proper form and function of the dentition, if prescribed in a Treatment Plan (attending Dentist's statement), and consisting of the initial and subsequent installation of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of existing malocclusion and its attendant sequelae through the correction of malposed teeth.

ORTHODONTIC PAYMENT SCHEDULE

The Orthodontic Expense Benefit has a lifetime maximum benefit of $2,000. In situations determined to be Medically Necessary (not cosmetic), the lifetime maximum does not apply to children age 18 and younger.

Payment for comprehensive orthodontics will be processed in two (2) equal payments (subject to continuation of treatment and/or eligibility for orthodontic benefits at the time services are rendered). The first payment will be made upon insertion of appliances. The second and final payment will be upon the completion of the first 12 months of treatment.

Oral surgery is covered as a medical expense, subject to the deductible, coinsurance, and out-of-pocket maximum.

EXCLUSIONS AND LIMITATIONS: SERVICES NOT COVERED BY THIS DENTAL PLAN

1. To be eligible for coverage, a service must be required for the prevention, diagnosis, or treatment of a dental disease, Injury, or condition. Services not dentally necessary are not covered benefits. The dental plan is designed to assist you in maintaining dental health. The fact that a procedure is prescribed by your Dentist does not make it dentally necessary or eligible under this program. Delta Dental can request proof (such as x-rays, pathology reports, or study models) to determine whether services are necessary. Failure to provide this proof may cause adjustment or denial of any procedure performed.
2. Services for injuries or conditions that are compensable under Workers Compensation Employers Liability Laws; services provided to the eligible patient by any Federal or State Government Agency or provided without cost to the eligible patient by any municipality, county, or other political subdivision.
3. Services with respect to congenital or developmental malformations (including TMJ and replacing congenitally missing teeth), cosmetic surgery, and dentistry for purely cosmetic reasons (e.g., bleaching, veneers, or crowns to improve appearance).
4. Services provided in order to alter occlusion (change the bite); replace tooth structure lost by wear, abrasion, attrition, abfraction, or erosion; splint teeth; or treat or diagnose jaw joint and muscle problems (TMJ).
5. Specialized or personalized services (e.g., over dentures and root canals associated with over dentures, gold foils) are excluded and a benefit will be allowed for a conventional procedure (e.g., benefiting a conventional denture towards the cost of an over denture and the root canals associated with it. The patient is responsible for additional costs.)
6. Prescribed drugs, analgesics (pain relievers), fluoride gel rinses, and preparations for home use.
7. Procedures to achieve minor tooth movement.
8. Experimental procedures, materials, and techniques and procedures not meeting generally accepted standards of care.
9. Educational services such as nutritional or tobacco counseling for the control and prevention of oral disease. Oral hygiene instruction or any equipment or supplies required.
10. Services rendered by anyone who does not qualify as a fully licensed Dentist.
11. Charges for hospitalization, including hospital visits or broken appointments, office visits, and house calls.
12. Services performed prior to effective date or after termination of coverage. Benefits are payable based on date of completion of treatment.

13. Services performed for diagnosis such as laboratory tests, caries tests, bacterial studies, diagnostic casts, or photographs.
14. Temporary procedures and appliances, pulp caps, occlusal adjustments, inhalation of nitrous oxide, analgesia, local anesthetic, and behavior management.
15. Procedures or preparations which are part of or included in the final restoration (bases, acid etch, or micro abrasion).
16. Transplants, implants, and procedures directly associated with implants including crowns and bridgework and their restoration and their maintenance or repair.
17. Periodontal charting, chemical irrigation, delivery of local chemotherapeutic substances, application of desensitizing medicine, synthetic bone grafts, and guided tissue regeneration.
18. Post removal (not in conjunction with root canal therapy).
19. Completion of claim forms, providing documentation, requests for pre-determination, and services submitted for payment more than 12 months following completion.
20. Separate fee for infection control and OSHA compliance.
21. Maxillofacial surgery and prosthetic appliances.

This is a general description of your dental plan to be used as a convenient reference, and some exclusions and limitations may not be listed.

11. VISION BENEFITS

Your vision benefits are provided through Davis Vision, Inc. You and your eligible dependents are covered in accordance with the eligibility rules established by the Board of Trustees, and as shown in the Schedule of Benefits.

Eye Examination

You and your eligible dependents receive full coverage for one complete eye examination every 12 months. The limitation of one examination every 12 months does not apply to a dependent child under the age of 19. The examination includes a dilation as professionally recommended. Fitting and follow-up of contact lenses is included when an active member or dependent selects plan lenses. Unless a participating provider or ophthalmologist recommends that a more frequent examination be rendered, subject to the approval by Davis Vision, eye examinations are limited to this frequency. In no event will a re-examination be authorized for a patient no longer eligible under the Plan.

Examinations are paid in full by the Plan only if they are performed by a Davis Vision participating network provider.

You and your eligible dependents have the option of having an eye examination performed by an optometrist or ophthalmologist who is not in Davis Vision's network of providers. The maximum reimbursement for eye examinations performed by providers who do not participate in the Davis Vision network is $100.

Eyeglasses (Lenses and Frames)

You and your eligible dependents can receive eyeglasses once every 12 months.

Eyeglasses are paid in full by the Plan only if they are performed by a Davis Vision participating network provider.

The Plan provides a selection of frames that include a wide assortment of high quality, current designer frames from *the collection of eyeglasses* available at every Davis Vision participating provider's office. Frames in the "Fashion or Designer" collections are paid in full by the Plan. There are some optional frames that require you to pay a copayment.

If you choose <u>not</u> to obtain eyeglass frames from the selection of frames offered by Davis Vision, you can receive a $150 credit toward a network or non-network provider's own eyeglass frames.

Contact Lenses

You and your eligible dependents can receive contact lenses every 12 months, in lieu of eyeglasses. When purchased at a Davis Vision facility, the Plan will cover the contact lenses in full, including evaluation, fitting and follow-up care.

If you elect not to receive contact lenses from a Davis Vision supplier, the contact lenses will be provided at no cost to you. If you wish to receive contact lenses from a Davis Vision provider's own supply of contact lenses, the Plan will provide you with an allowance of $105 toward the purchase of contact lenses.

If you choose to obtain services from a non-participating provider, the Plan will provide a reimbursement of up to $150 for elective contact lenses. Medically Necessary contact lenses will be covered in full with prior approval. This dollar limit for contact lenses does not apply to children under the age of 19.

Safety Eyeglasses

You can receive safety eyeglasses from the Davis Vision collection once every 12 months. Your dependents are not eligible for coverage of this benefit. This is an in-network benefit only with the cost of the safety eyeglasses paid in full by the Plan for covered services.

You may select from the "designer selection" of frames from the exclusive "Fashion" safety collection". One pair of safety eyewear may be received in addition to dress eyewear. This benefit must be used in conjunction with the routine eyewear benefit.

Laser Vision Correction

You and your eligible dependents can obtain discounted services from an exclusive network of Laser Providers. You and your covered dependents are entitled to receive up to 25% off the usual and customary charges or 5% off any advertised special. For a listing of laser providers participating in Davis Vision's network, please refer to their directory.

Low Vision Services

You and your eligible dependents are entitled to a comprehensive low vision evaluation once every five years and low vision aids up to the Plan maximum. Up to four follow-up care visits will be covered during the five-year period.

The following are the lenses and or coatings that are included as part of the Davis Vision program:

- Plastic or glass single vision, bifocal or trifocal lenses, in any prescription range.
- Glass grey #3 prescription lenses.
- Oversize lenses.
- Post-cataract lenses.
- Tinting of plastic lenses.
- Polycarbonate lenses for dependent children, monocular patients and patients with prescriptions +/-6.00 diopters or greater.
- Sideshields (fixed or removable).

There are also optional frames, lens types, or coatings available for which you will be charged a discounted fixed fee. A copayment may apply.

Network Providers

Network providers are licensed eye care providers in both private practice and retail locations located throughout Connecticut, as well as nationally. They have agreed to provide high quality, comprehensive vision care services, which are carefully monitored by Davis Vision's optometric experts. Stringent standards have been established for eye examinations, testing equipment and all other professional services rendered.

Davis Vision is an independent and separate entity, not affiliated with or under the control of the Board of Trustees of the Fund. The Trustees cannot take responsibility for the results of the examinations received through Davis Vision providers nor will the Trustees interfere in the professional relationship. The Davis Vision network of licensed providers are both in private practice and retail locations, and are credentialed to ensure that quality standards are maintained.

Please access Davis Vision's website at www.davisvision.com and utilize the "Find a Doctor" feature, or call 1-800-999-5431 to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the network providers nearest you.

HOW TO USE THE VISION BENEFIT

When you want to take advantage of this Vision Benefit, all you need to do is:

1. Call a network provider of your choice and schedule an appointment,

2. Identify yourself as a Davis Vision Participant covered by the Heat and Frost Insulators Local No. 33 Health Fund's Plan, and

3. Provide the office with your Fund I.D. number, your name, and the date of birth of the individual you wish to schedule for an eye examination and possibly need eyeglasses.

The provider's office will verify your eligibility for services, and no claim forms or I.D. cards are required.

For more information about Davis Vision you can visit the Davis Vision website for more information about this company and the network of providers that participate in this program:

www.davisvision.com
or call 1-800-999-5431

If you have not yet registered on the Davis Vision website, please select the "First Time Registrant" button to establish a user name and password. When completing the registration form, your I.D. number is the number on your Fund I.D. card.

The following are commonly asked questions and answers regarding this program:

After an eye examination, when will I receive my eyeglasses?

Your eyeglasses will be delivered to your provider from the laboratory, generally within five business days. More delivery time may be needed when out-of-stock frames, ARC (anti-reflective coating), specialized prescriptions, or a participating provider's frame is selected.

Can I go to an out-of-network optometrist?

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit if you select a provider who participates in the Davis Vision network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Davis Vision
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Only one claim per service may be submitted for reimbursement every business cycle. To request claim forms, please visit the Davis Vision website at www.davisvision.com or call 1-800-999-5431.

May I use the benefit at different times?

You may "split" your benefits by receiving your eye examination and eyeglasses (or contact lenses) on different dates or through different provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one provider. Continuity of care will best be maintained when all available services are obtained at one time from either a network or an out-of-network provider. To maximize your benefit value, it is recommended that all services be obtained from a network provider.

EXCLUSIONS

The following items are not covered by this vision program:

1. Medical treatment of eye disease or Injury.
2. Vision therapy.
3. Special lens designs or coatings, other than those previously described.
4. Replacement of lost eyewear.
5. Non-prescription (plano) lenses.
6. Contact lenses and eyeglasses in the same benefit cycle.
7. Services not performed by licensed personnel.
8. Two pairs of eyeglasses in lieu of a bifocal.

12. HEARING BENEFITS

The Fund provides a Hearing Benefit for you and your eligible dependents. The benefit provides full coverage of all charges related to the evaluation of a hearing loss and the fitting and dispensing of a hearing aid or aids, provided the services are received from the University of Connecticut Speech and Hearing Clinic (Hearing Clinic). **No expenses for hearing testing are covered by the Plan except those provided by the University of Connecticut Speech and Hearing Clinic.**

The Fund will pay 50% of the cost of hearing aids dispensed by the Hearing Clinic. Covered charges for hearing aids include the full range hearing appliances, provided the hearing aid or aids are deemed appropriate for the individual with the hearing loss by an audiologist at the Hearing Clinic. This benefit also includes all the follow-up sessions for the individual with the hearing loss to adjust to the hearing appliance at the Clinic. **This is an exclusive benefit only provided through the Speech and Hearing Clinic at the University of Connecticut, in Storrs.**

Hearing Evaluations

If you or your eligible dependent would like a hearing evaluation, contact the Fund Office to verify your eligibility. After eligibility has been established, the Fund Office will assist you in scheduling an appointment with the University of Connecticut Speech and Hearing Clinic, in Storrs.

At the University of Connecticut Speech and Hearing Clinic, you will be given a series of tests by an audiologist who is licensed by the State of Connecticut Department of Public Health and certified by the American Speech-Language-Hearing Association. Results and recommendations will be explained to you at the time of your appointment, and a written report will be mailed to you at a later date.

You and your dependents may receive a hearing evaluation once every three (3) years, or more frequently as recommended by an audiologist from the University of Connecticut Speech and Hearing Clinic.

Hearing Aids

An extensive selection of hearing aids is available through the University of Connecticut Speech and Hearing Clinic. The hearing aid(s), if prescribed, will be supplied by the Hearing Clinic and paid by the Fund at 50% of the charges per hearing appliance. Covered Charges will include any necessary accessories, such as ear molds and an initial supply of batteries. Eligible Participants may receive a hearing aid or appliance only as recommended by an audiologist from the Hearing Clinic. The Fund will not replace lost, stolen, or damaged hearing aids or appliances. Hearing appliances, however, do have warranties. The typical warranty is for one (1) year. The warranty will be explained to you by the staff at the Hearing Clinic and is part of the program the Fund arranges with the Hearing Clinic and the manufacturers of the hearing aids.

Medical Evaluation

A medical evaluation by a Physician is required prior to the actual fitting of a hearing aid (instrument or appliance). This evaluation is necessary to assure that you do not have a medical condition which would prevent the use of a hearing aid or which would be aggravated by the use of a hearing aid. The medical evaluation can be provided by the Physician of your choice, or you can request the Hearing Clinic to provide a list of Board Certified Physicians in your area. You will be responsible for arranging this appointment. The claim for charges incurred for the Physician will be processed in accordance with the provisions of the Plan. We encourage you to use a network provider (Anthem BC/BS) as the charges will be subject to the standard copayment and submitted directly to the Fund Office for processing.

Return Policy

If you are dissatisfied with the hearing aids dispensed, you can return the hearing aid or aids within 30 days to the Hearing Clinic and you will only be responsible for a $50 payment for the processing and handling. Any fees you paid for the balance of the charges for the hearing aid or aids will be refunded to you as the Fund is responsible for all the charges associated with the evaluation and fittings.

Other Information

1. To assist Covered Persons in effectively managing their hearing impairments, group and individual aural rehabilitative instructive classes are available at the Hearing Clinic.
2. Minor repairs to hearing aids and ear molds will be available at the Hearing Clinic. Major repairs are arranged by the audiologist with the manufacturer or an independent laboratory.
3. The number of ear molds and hearing aids and the frequency of their repair or replacement will be determined by the Hearing Clinic's audiologist, according to the individual's needs and generally accepted guidelines of normal wear and maintenance.
4. In the case of children, a parent or other responsible adult must accompany the child to all appointments.
5. Hearing aids will be provided only through the Speech and Hearing Clinic at the University of Connecticut in Storrs, Connecticut. If you need directions, please contact the Fund Office.

13. MEDICAL EXPENSES NOT COVERED AND GENERAL PLAN LIMITATIONS AND EXCLUSIONS

In addition to any limitations or specific exclusions described in this Summary Plan Description (booklet), there are a number of medical charges and procedures not covered along with general limitations and exclusions that apply to all benefits unless otherwise indicated. No payment will be made for expenses incurred by you or any of your eligible dependents for any of the following:

No payment will be made for the following medical expenses:

1. Services or supplies **not listed as Covered Charges**.
2. **Charges in excess** of the limitations applicable to the treatment of inpatient and outpatient mental and nervous disorders and alcohol and substance use disorder benefits.
3. Charges incurred for services, treatment, or supplies allowable **under the Dental Expense Benefit** (see Section 10), except for treatment of tumors or cysts, or treatment rendered within 90 days of an accidental Injury to natural teeth, or as otherwise specifically included.
4. Elective or **cosmetic surgery**, except as required to correct a condition caused by an accident, surgery, or burn, provided such treatment begins within 180 days of the condition's onset.
5. **Eye** refractions, eyeglasses, contact lenses or their fittings, unless covered under the Vision Benefit as described in Section 11.
6. **Hearing aids** or their fittings; unless covered under the Hearing Benefit as described in Section 12.
7. **Transportation**, except for local ambulance services required due to Medical Emergency.
8. Accidental bodily Injury or Illness arising out of and in the course of your **employment**.
9. Services and supplies for the diagnosis and/or treatment of weight loss, including **diet control, diet supplements, diet prescriptions, weight loss programs, exercise programs, gym memberships, and nutritional counseling**.
10. Non-medical services such as employment counseling **and/or educational therapy** for learning or related disabilities.
11. **Vitamins**, except as deemed Medically Necessary or explicitly covered under the Preventive Services benefit, whether or not prescribed by a Physician, and any prescriptions or medications used for weight control, unless otherwise specifically included.
12. **Prescriptions** for animals.
13. **Prescription drugs**, except as payable through OptumRx (see Section 9).
14. Any maternity charges incurred for the **pregnancy of a surrogate mother.** In addition, only maternity charges for an Employee's dependent **daughter's** pregnancy that are required under the Affordable Care Act will be considered a covered expense. Expenses of the newborn are excluded under the Plan.
15. Any charges related to the **adoption of a child**.

16. Charges for or in connection with **transsexual** surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, such surgery.
17. Any charges for **telephone consultations** with a Physician. On-line internet consultation services will be recognized by the Plan.
18. Charges directly or indirectly related to homemaker services or care primarily for rest, custodial, domiciliary or **convalescent care**, including convenience and comfort items.
19. Charges incurred for **personal or comfort** items such as:
    - Personal care kits provided on admission to a Hospital.
    - Television.
    - Telephone.
    - Infant photographs.
    - Complimentary meals.
    - Birth announcements.
    - Any other item not strictly provided for the treatment of an Illness or Injury.
20. **Therapeutic devices or appliances**, support garments, and other non-medical substances, regardless of the intended use.
21. Charges incurred for or in connection with treatment, services, or supplies for cessation of **cigarette smoking** that are **not** prescribed by a Physician (covered under the Prescription Drug Benefit, see Section 9).
22. Any services, treatment, or supplies for or in connection with **temporomandibular joint dysfunction**.
23. **Massage** and/or Rolfing therapy, unless approved in advance by a licensed Physician and Medical Review (see Section 7) as an effective alternative to physical therapy.
24. Services, supplies or treatments that are **not** prescribed, recommended or **approved as Medically Necessary** by an attending Physician or exceeding the Reasonable and Customary limits. This exclusion also applies to any Hospital confinement or any part of a confinement not approved by Hines & Associates (see Utilization Review Section 7).
25. Fees which are in **excess of the Reasonable and Customary charges** for services, supplies or treatment.
26. **Cosmetic surgery**, including but not limited to liposuction, etc., unless required because of:
    - An accidental bodily Injury, provided treatment occurs within one year from the date of the accident.
    - Reconstructive surgery that is incidental to or follows surgery resulting from trauma, infection, or other disease of the involved part.
    - Reconstructive surgery, when required because of a congenital disease or anomaly of an eligible dependent child that has resulted in a functional defect.

This cosmetic surgery exclusion does not apply to charges recognized in accordance with the Women's Health and Cancer Rights Act of 1998, including reconstruction of the breast on which a mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; breast prosthesis; surgical brassieres and treatment of physical complications of all stages of mastectomy including lymphedemas.

27. Expenses incurred as a result of past or present services in the **armed forces** of any government.
28. Expenses incurred as a result of participation in a **felony**, riot or insurrection.
29. **Administrative charges** incurred for the completion of claim forms, mailing fees and stop payment on check fees.
30. Charges incurred for **handling fees**, unless directly related to test results.
31. Expenses incurred for functional **visual training**.
32. **Genetically engineered** biological products.
33. Meals, meal preparation, **personal comfort items**, other equipment such as, but not limited to, air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercise equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, non-prescription drugs and medicines, first-aid supplies and non-Hospital adjustable beds, **convenience items**, housekeeping services, and protective or companion services.
34. Expenses related to **surrogate parenting**.
35. An Injury or an Illness that is **employment related** or that is covered under the Workers' Compensation Law, occupational disease law, or similar laws.
36. Expenses incurred during confinement in a **Hospital owned or operated by the federal Government**, unless required by law.
37. Charges for which you or your eligible dependent is **not legally required to pay**, including charges that would not have been made if no insurance coverage existed.
38. **Charges for Custodial Care**, which are institutional services and supplies, including room and board, which are designed primarily to assist the individual in the activities of daily living rather than connected to a medical program, which can be expected to improve the individual's medical condition.
39. Charges for claims that are **not received by the Fund Office**, along with all required supporting information necessary to process the claim, **within 15 months** from the incurred date.
40. Loss caused by war or any **act of war** (this exclusion does not apply to life insurance benefits).
41. Any expenses, to the extent that you or your eligible dependent is in any fashion paid or entitled to payment for those expenses by or through a **public program**.
42. **Experimental drugs** or substances not approved by the Food and Drug Administration, or for drugs labeled: "Caution limited by federal law to investigational use" or drugs not approved to treat a specific diagnosis, except as may be prescribed during Approved Clinical Trials.

43. **Experimental Procedures or treatment** methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society except as otherwise stated elsewhere in this Summary Plan Description as required coverage under the federal Affordable Care Act (*i.e.,* **Approved Clinical Trials**).

44. **Medical treatment or procedures** unless proven to be safe, efficacious, scientifically established therapies, or unless found to have a demonstrable benefit for a particular Illness or disease. Ineffective or Experimental surgical or medical treatments or procedures, research studies or other Experimental health care procedures under continued scientific testing and research with questions to safety and efficacy are not covered unless approved by the Fund's Utilization Review Program (Section 7).

45. Services, treatments, or supplies **furnished by or at the direction of the United States Government**, any state or other political subdivision thereof, or any of its agents or agencies.

46. Laser **vision correction surgery**, including but not limited to PRK, keratotomy or LASIK surgery. A discount may be available under the Vision Benefit, see Section 11.

47. Services of a **faith healer**.

48. Any expenses related to **routine foot care** including, but not limited to treatment, services or supplies in connection with:

    - Corns.
    - Calluses.
    - Nails.
    - Weak, strained, or flat feet.
    - Any instability or imbalance of the feet.
    - Shoes or any other inserts.

49. **Travel**, except as specifically included in this Plan.

50. Any expenses related to services or treatment received for an accident or Injury resulting **from driving while intoxicated with alcohol or illegal drugs and for which a legal arrest and conviction for "DUI" is imposed**.

51. Services of **interns, residents and Physicians in training**.

52. Charges incurred for **speech therapy** unless required for rehabilitation due to an accident, Illness, or mandated for treatment of autism.

53. Diagnosis and treatment of **learning disabilities, including but not limited to educational, training programs, visual training, and speech therapy, unless rehabilitation is to restore lost skills** or mandated for the treatment of autism.

54. Medical **treatment of obesity**, including but not limited to specialized medical weight reduction programs and medications, except for individuals determined to be "morbidly obese," which is at least 100% more than the ideal weight of an individual's normal body weight for the individual's age, sex, height and body frame, whereas medical dietary and drug therapy will be recognized as a Covered Expense, subject to the Utilization Review requirements, see Section 7.

55. Any services or supplies for or in connection with **acupuncture** unless a referral is made by an independent Physician and the services are pre-approved as medically appropriated by Hines & Associates (see Section 7).

56. Any medical treatment, services or supplies **not covered by the Fund's stop-loss insurance**.

57. Any expenses related to **transsexual surgery**.

58. **Biofeedback** when not in conjunction with other medical services that have been approved by the Utilization Review Program.

59. Laser therapy for the purpose of ameliorating or modifying **snoring** unless significant associated sleep apnea has been demonstrated subject to the approval of the Utilization Review Program (see Section 7).

60. Care and **treatment of hair loss**.

61. Antibacterial **soaps**/detergents, **shampoos**, toothpastes and **mouthwash/rinse**.

62. **Hypnosis/hypnotherapy**.

63. **Magnetic therapy**.

64. **Scleral therapy** as the initial treatment for the diagnosis of varicose veins.

65. **Court-ordered treatment**, unless otherwise recognized by the Plan.

66. **Auto-transfusion and storage of blood**, except autologous blood preparation and transfusion.

67. **Genetic tests**, including pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents, and any associated genetic counseling. However, benefits may be payable if determined medically appropriate and pre-approved by Hines & Associates (see Section 7).

68. Any charges or expenses for which a **third party may be liable**, see Section 21.

69. Charges related to **transplants**.

70. The following limitations and exclusions apply to **preventive services**:

    - Preventive services are covered only when performed for preventive screening reasons and billed under the appropriate preventive services codes. Services performed for diagnostic reasons are covered under the applicable Plan benefit, not the preventive services benefit. A service is considered diagnostic if the Participant had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.
    - Services covered under the preventive services benefit are not also payable under other portions of the Plan.
    - The Plan will use reasonable medical management techniques to control costs of the preventive services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific preventive services, which must be satisfied in order to obtain payment under the preventive services benefit.

- Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus, are not covered.
- Examinations, screenings, tests, items, or services are not covered when they are investigational or experimental, as determined by the Plan.
- Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:
  (i) when required for education, sports, camp, travel, insurance, marriage, adoption or other non-medical purposes, unless part of an annual or routine physical;
  (ii) when related to judicial or administrative proceedings;
  (iii) when related to medical research or trials (other than for Approved Clinical Trials); or
  (iv) when required to obtain or maintain employment or a license of any kind.
- Services related to a man's reproductive capacity, and contraception.

14. WORKERS' COMPENSATION BENEFITS

Medical expenses covered by the Fund are for services and supplies received for the treatment of **non-occupational** bodily injuries and Illnesses. If you incur a work-related Injury or Illness (one which arises out of or in connection with your employment), your claim for any medical expenses arising out of or in connection with that Injury or Illness must be submitted through your Employer for Workers' Compensation coverage. No benefits are payable by the Fund for such medical expenses unless the Workers' Compensation Commissioner determined that the underlying Injury or Illness is not compensable. Plan provisions will apply in all circumstances where Workers' Compensation insurance is required including individuals that are self-employed.

However, if you have been notified that your Employer is contesting liability for your Workers' Compensation claim and the Fund has received a formal Notice to Contest Liability from your Employer or its Workers' Compensation insurance carrier, the Fund may, at its sole discretion, pay Covered Expenses connected to a claimed work-related Injury or Illness, pending a formal ruling of the Workers' Compensation Commissioner. In any event, before payment for Covered Expenses arising out of or in connection with a claimed Workers' Compensation Injury will be advanced by the Fund, you will be required to sign a Reimbursement Agreement and Consent to Lien (see Section 21). In order for the Fund to consider exercising its discretion to advance payment for Covered Expenses including Weekly Disability Benefits connected to a Workers' Compensation claim, the Notice to Contest Liability must challenge liability for the underlying Illness or Injury, and not just for particular medical expenses that are contested by your Employer or its Workers' Compensation insurance carrier for one reason or another. In other words, the Fund will not advance payment for Covered Expenses connected to a work-related Injury or Illness simply because your Employer or its Workers' Compensation carrier has contested certain specific expenses.

Although charges relating to an occupational Injury or Illness must be submitted to Workers' Compensation; the Life Insurance and other health benefits will continue for you and your eligible dependents for charges incurred due to non-occupational accidental bodily injuries or Illnesses, as long as you maintain eligibility.

Where a claim for Workers' Compensation is settled by stipulation or agreement, you cannot claim benefits for the same disability from the Fund. If benefits are paid by the Fund in error, you must reimburse the Fund for any payments to you or your eligible dependents or providers, and all costs of collection, including attorney's fees and court costs. Failure to reimburse the Fund in full for all claims and benefits paid by the Fund determined to be work related will be pursued legally by the Fund to recover all benefits paid that were work related along with all legal and court costs. In addition, any amounts considered an overpayment by the Fund will be used as an offset against future claim and benefit payments.

15. LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

LIFE INSURANCE

In the event of your death from any cause—on or off the job—while you are an insured Participant, the proceeds as shown in the Schedule of Benefits will be paid to your named beneficiary. A Participant's Life Insurance Benefit is provided by an insurance company retained by the Board of Trustees (the Prudential Life Insurance Company). You should tell your immediate family about the life insurance you have through the Fund.

Assignment

You may **not** assign your Life Insurance benefits. This means you may not give or transfer your Life Insurance offered through this Plan to any other person.

Conversion Privilege

If your eligibility for benefits under the Plan terminates, you will have the opportunity to convert your Life Insurance to an individual policy. You must notify the Fund Office immediately because your rights to convert the policy end 31 days after your coverage under the Plan terminates. There are additional limitations and exclusions that apply, so you should check with the Fund Office for more information.

ACCIDENTAL DEATH AND DISMEMBERMENT

Accidental Death and Dismemberment Benefits are payable, provided the insurance company retained by the Board of Trustees receives written proof that the loss occurred as a result of an accidental bodily Injury and independently of all other causes and occurrences, within 90 days after the date of the Injury.

- Loss of Life ..... Full Principal Sum
  Shown in the Schedule of Benefits

- Loss of two limbs, sight in both eyes, or loss of one limb and sight in one eye ..... Full Principal Sum
  Shown in the Schedule of Benefits

- Loss of one limb or sight in one eye ..... One-half of the Principal Sum
  Shown in the Schedule of Benefits

Loss of limb means complete severance at or above the wrist or ankle joint.

Loss of sight means the total and irrecoverable loss of sight.

If more than one of the losses set forth above is suffered as a result of any one accident, not more than the full amount of Accidental Death and Dismemberment Benefits will be payable.

The Accidental Death and Dismemberment Benefits are insured through an insurance company retained by the Board of Trustees.

Limitations and Exclusions

No payment will be made for death or any loss under the Accidental Death and Dismemberment Benefits resulting from or caused directly, wholly, or partly by:

1. Bodily or mental infirmity, ptomaines, bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound), or disease or Illness of any kind.
2. Suicide or attempted suicide while sane or insane.
3. Intentionally self-inflicted Injury.
4. Insurrection, act of war for any country.
5. Injury or death during service in the armed forces of any country while such country is engaged in war.
6. Participation in, or as a result of participation in a felony.
7. Travel or flight as pilot or crewmember in any kind of aircraft including, but not limited to, a glider, a seaplane, or a hang kite.
8. Travel or flight in or descent from any kind of aircraft as a passenger, pilot, crew member or Participant in training that is owned, operated, or leased by or on behalf of the Policyholder, a participating Employer or the armed forces; or being operated for any training or instructional purpose.
9. Parachuting, skydiving, bungee cord jumping, flying, ballooning, hang-gliding, parasailing or any other aeronautic activities except as a fare-paying passenger on a commercial aircraft.
10. Voluntary use of controlled substances as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by a Physician for the person.
11. Driving while intoxicated as defined by applicable state law.

BENEFICIARY

You may name anyone you wish as your beneficiary and you may change your beneficiary at any time by filling out the proper form and filing it with the Fund Office. If a beneficiary is designated, the beneficiary's consent is not required to change the beneficiary. If your beneficiary predeceases you, such beneficiary's interest will automatically terminate. If you name more than one beneficiary, but do not say how much each beneficiary should receive, the total amount will be shared equally by all surviving beneficiaries. If there is a court order that requires you to name a specific beneficiary, such order will only be recognized if on file at the Fund Office at the time of your death. If there is no living beneficiary when you die, the insurance company will make the payment to your surviving spouse; if none, to your surviving children in equal shares; if none, to surviving parents in equal shares; and if none, to your surviving brothers and sisters in equal shares; and if none, to your estate. However, if no named beneficiary is on file, the insurance company (at its discretion) has the option to make the payment to the administrators of your estate.

Facility of Payment

If you die and your estate is the beneficiary, but no administrator on your estate has been appointed within a reasonable period of time following your death, or your eligible dependent is not legally capable of giving a valid receipt for a benefit payment, the Fund and/or the insurance company, at their sole discretion, have the right (if no legal guardian is appointed) to pay the party it believes is entitled to such payment by reason of having incurred funeral or other expenses incident to the last Illness or death of the claimant, but not to exceed the amount allowed by state law. Once such a payment is made, the Fund and/or insurance company has no further obligation with respect to the amount paid.

TERMINATION OF COVERAGE

When your coverage terminates in accordance with the termination of eligibility rules of the Plan (as described in Section 1 of this booklet), your Life Insurance and Accidental Death and Dismemberment Benefits will cease.

There is no cash value to either the Life Insurance benefit or the Accidental Death and Dismemberment benefit.

16. DISABILITY INCOME BENEFITS

If, while covered under the Fund and working or available for work in Covered Employment, you become Totally Disabled, unable to work, and are under the continuous care of a Physician legally licensed to practice medicine, you will receive the Disability Income Benefits shown in the Schedule of Benefits, provided your total disability is the result of:

- Any Injury **not** arising out of or in the course of employment; or
- Any Illness or disease **not** entitling you to benefits under any Workers' Compensation, occupational disease law, or similar legislation.

However, if you are involved in a motor vehicle accident to which no-fault insurance applies, Disability Income Benefits from the Fund will not be payable for any week for which weekly indemnity is paid or payable under the applicable no-fault insurance law. If the no-fault loss of wages benefit is less than $550 per week, the Fund will pay the difference. Any such payments will be counted towards the 26-week maximum.

In addition, no benefits are payable during periods when you are collecting unemployment benefits.

Once you begin collecting a pension from a retirement plan sponsored by Local No. 33 (Heat and Frost Insulators Local No. 33 Pension Fund), you are not eligible and therefore cannot collect Disability Income Benefits, even though you may continue to be eligible for coverage in the Health Plan. If you receive both a monthly pension and Disability Income Benefit for the same time period, you are liable and required to repay any such Disability Income payments to the Health Fund.

These benefits will commence on the first day of disability due to Injury and on the eighth day due to an Illness and will continue while you remain totally disabled for a maximum of 26 weeks for any one continuous period of disability due to the same or related cause(s).

During your disability period, the Fund will freeze your Administrative Account (not draw $1,500 per month) to maintain your eligibility for up to a maximum of three (3) months. While you are disabled, the Fund will not deduct $1,500 per month from your Administrative Account for a maximum of three (3) months while you are disabled and collect Weekly Disability Income Benefits. After the maximum extension of coverage for three (3) months, the Fund will resume deducting $4,500 on the last business day of each calendar quarter in accordance with the continued eligibility rules of the Fund, although you may continue to receive Disability Income Benefits beyond the 3 months. In the event your Administrative Account is exhausted before you can return to work, you will be offered COBRA self-pay coverage (see Section 22).

Successive Disabilities

Separate periods of disability, resulting from the same or related causes, will be deemed one period of disability unless separated by your return to work in Covered Employment for at least two (2) consecutive weeks (80 hours over consecutive workdays). Separate periods of disability resulting from unrelated causes will be deemed one period of disability unless separated by your return to active Covered Employment for at least one (1) full day. In addition, Disability Income Benefits are limited to a maximum of fifty-two (52) weeks in any one hundred and four (104) consecutive week period.

Limitations and Exclusions

It is not necessary to be confined to your home to collect benefits, but you must be under the care of a Physician. **No benefits are payable for**:

1. Any day you are not under the care of a Physician. It is understood that no disability will be considered to have started until you have been treated personally by a Physician.
2. Any day you are receiving compensation or performing work of any kind, anywhere, for compensation or profit.
3. Any day you are released by your Physician to engage in work of any kind.
4. A disability due to accidental bodily Injuries arising out of and in the course of your employment.
5. Those days for which you are receiving compensation for lost wages from automobile reparation (no-fault) insurance or its equivalent, Workers' Compensation, Unemployment Compensation, or any company-sponsored retirement plan.
6. Any day immediately following a request for an independent examination selected and paid for by the Fund to verify the nature and extent of your disability, which you refuse.
7. Services for which benefits are not payable, according to the Limitations and Exclusions Section 13.

NOTE: *Payments received under this benefit are considered as taxable income and must be reported on your federal, state or any other applicable income tax returns. The Fund Office will arrange to have taxes withheld from your disability payments upon your request. The Fund will deduct the FICA tax on your behalf and pay it to the appropriate government agency.*

17. MISCELLANEOUS PROVISIONS

Misrepresentation and Fraud

In the event a Covered Person receives benefits as a result of misleading representation or any type of false information or other fraudulent representations to the Fund, such person will be liable to repay all amounts paid by the Fund. Fraudulent claims include such person's failure to disclose any other group health coverage in which such person is entitled to receive reimbursement of a claim submitted to the Fund for payment, and Third Party liability claims (see Section 21 Subrogation). The Covered Person will be prosecuted for fraud and held liable for all costs of collection, including interest and attorney's fees or will have future claims offset by the overpayments.

Overpayments

If a claim payment is made to a Participant or assigned to a provider that is later determined to be an overpayment, the Board of Trustees may offset future benefit payments in order to recover said overpayment.

Notices Sent to Addresses of Participants

The Board of Trustees and/or the Fund Office will give notice by mail to Participants of actions taken with respect to eligibility, claims, and other important matters.

All such notices will be sent to your address, as it appears in the Fund's records. To protect yourself and your rights, you must be sure the Fund Office always has your current address.

If you fail to notify the Fund Office of your current address, you may miss receiving an important notice and might lose valuable rights or benefits. You may even lose coverage.

Any notice sent to you at the address in the Fund's records will be deemed to have been received by you. The time in which you must reply to such a notice will **not** be extended because you did not give the Fund Office your current address.

COST SAVINGS ADVICE

Physician's Fees and Treatment Plans

Whenever possible, you should use an in-network Physician, Hospital, laboratory, or imaging provider. If you use an out-of-network provider, you should ask your Physician about his treatment and medical fees, as it is important to know whether the Fund will recognize these fees as "Reasonable and Customary." Remember that coverage under this Plan for out-of-network services is limited to the Reasonable and Customary charges for the services in question and subject to out-of-network deductibles and coinsurance. You are liable for charges above Reasonable and Customary charges billed by a Physician or other provider and such amounts will not count towards your annual out-of-pocket maximum. You do not have this risk of being billed above the allowance recognized by the Fund if you utilize a network provider.

Bills and Unnecessary Services

Review your out-of-network medical bills and your Explanation of Benefit (EOBs) forms for in-network claims to assure correct charges and payments. When deciding upon the methods for treatment, avoid requesting unnecessary services. For example, you may reduce your expenses by:

- Avoiding weekend Hospital admissions.
- Getting a second surgical opinion.
- Taking advantage of outpatient surgery.
- Contacting the Fund's Utilization Review Program (refer to Section 7).
- Using generic drugs.

By adhering to these suggestions, you may utilize your benefit to its fullest, while simultaneously cutting medical costs.

Cash Payment for Self-Audit of Bills

From time-to-time, a Hospital or other health care provider may charge for services or medications not actually provided. You may be charged for example, for an extra day in the Hospital. If you find a charge for a service or medication not provided, tell the Fund Office. If the Fund receives a credit for the billing error you identified, you will be paid 25% of that credit up to a maximum of $1,000 per bill or invoice.

18. COORDINATION OF BENEFITS

Duplicate Coverage of Medical and Dental Expenses

This Section describes the circumstances when you or your eligible dependents may be entitled to medical and/or dental benefits under this Plan and may also be entitled to recover all or part of your medical and/or dental expenses from some other source. It also describes the rules that apply when this happens.

There are several circumstances that may result in you and/or your eligible dependents being reimbursed for your medical and/or dental expenses not only from this Plan but also from some other source. This can occur if you or an eligible dependent is also covered by:

1. Another group or individual health care plan.
2. Medicare or some other government program, such as Medicaid, or a program of the U.S. Department of Veterans Affairs, or any coverage either provided by a federal, state or local government or agency, or any coverage required by federal, state or local law, including, but not limited to, any motor vehicle no-fault coverage for medical expenses or loss of earnings that is required by law.
3. Workers' Compensation.
4. If your spouse or dependent child is employed and covered by a high deductible health plan (HDHP) with a Health Savings Account (HSA), your spouse or child cannot be covered by this Plan. Pre-tax contributions to a HSA are not permitted if covered by another group health plan.

Duplicate recovery of medical and/or dental expenses can also occur if a third party is financially responsible for your medical and/or dental expenses because that third party caused the Injury or Illness giving rise to those expenses by negligent or intentionally wrongful action, (please refer to Section 21, Subrogation).

This Plan operates under rules that prevent it from paying benefits that together with the benefits from any other source described above, would allow you to recover more than 100% of medical and/or dental expenses you incur. In many instances, you may recover less than 100% of those medical and/or dental expenses from the duplicate sources of coverage or recovery. In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your eligible dependent actually recover some or all of your losses from a third party.

Furthermore, under the Coordination of Benefits provisions, an eligible dependent who is also covered under another group plan that includes programs such as a utilization review program, Hospital pre-admission certification, and continued stay review requirement will not receive any payment or compensation from this Fund for reductions in benefits paid by the "other plan" because of the failure of your eligible dependent to utilize the "other plan's" mandatory programs.

For example, if the "other plan" requires that your eligible dependent call them before a scheduled surgery or Hospital stay, and your eligible dependent fails to do so which results in a reduction in benefits or total denial of benefits from the "other plan," this Plan will not reimburse you or your eligible dependent for what the "other plan" failed to pay. These reductions or penalties may be for example, flat dollar reductions, or reductions of a percentage of benefits otherwise payable. In addition, if your eligible dependents are covered under an HMO or PPO

that is considered the "Primary Plan", they must utilize the providers and facilities required under their plan before the Fund will consider secondary payment.

The important thing to remember is that Coordination of Benefits (COB) is designed for just one purpose: to protect the Plan from unnecessary expenditures that are the responsibility of another insurance plan.

COORDINATION OF BENEFITS (COB) DEFINITIONS

Allowable Expense

Allowable Expense means any necessary Reasonable and Customary item of expense, at least a part of which is provided by one of the plans that covers the person for whom a claim is made. When the benefits from a plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

Plan

"Plan" refers to any of the following plans that provide full or partial health benefits for services on an insured or self-funded basis:

1. Group, blanket, or franchise insurance.
2. Group Blue Cross, group Blue Shield, group practice, and any other group HMO or prepayment plans.
3. Union welfare plans, Employer organization plans, or labor-management trustee plans.
4. Governmental programs or coverages required or provided by law. However, "plan" does not include any governmental program coverage that is not allowed by law to coordinate benefits.
5. Medicare, Title XVII of the Social Security Act of 1965, as amended to the extent permitted by law.

"Plan" will apply separately:

1. To each policy, contract, agreement, or other plan for benefits or services.
2. To that part of such policy, contract, agreement, or plan which reserves the right to consider the benefits or services of other plans in determining its benefits and to that part which does not.

Primary Plan

If a plan is considered "primary," it is responsible for paying benefits first in accordance with its benefits provisions.

Secondary Plan

If a plan is "secondary," it is responsible for paying benefits if any remain, after the primary plan has paid its share.

Coverage Under More Than One Group Health Plan

Many families that have more than one family member working outside the home and are often covered by more than one insurance plan. If this is the case with your family, **you must let the Fund Office know about <u>all</u> your coverages.**

Coordination of Benefits operates so that the combination of insurance coverage will be shared fairly in a consistent manner. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the Reasonable and Customary medical or dental expenses incurred**. Sometimes, the combined benefits that are paid will be less than the total expenses.

Which Plan Pays First – Order of Benefit Determination Rules

An individual plan (that is, a plan purchased by an individual), whether provided through a policy, subscriber contract, health care network plan, or group practice or individual practice plan, pays first; and this Plan pays second.

Group plans determine the sequence in which they pay benefits, or which plan pays first by applying uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules will be deemed by this Fund to be the primary plan.**

If the first rule does not establish a sequence or order of benefits, the next rule is applied and so on, until an order of benefits is established. The rules are:

Rule 1: Non-Dependent/Dependent

The plan that covers a person as an Employee, retiree, member or subscriber (that is, other than as a dependent), pays first, and the plan that covers the same person as a dependent pays second.

There is one exception to this rule. If the person is also a Medicare beneficiary:

1. Medicare is secondary to the plan covering the person as a dependent. However, if the dependent is the retiree's spouse and the retiree's spouse is covered under the Medicare Supplemental Program, Medicare is Primary.
2. Medicare is primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retiree). However, if the plan covers an individual as an Employee and not a retiree, the plan is primary and Medicare is secondary.

Rule 2: Dependent Child Covered Under More Than One Plan

The plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose birthday falls later in the calendar year pays second, if: (i) the parents are married; (ii) the parents are not separated (whether or not they ever have been married); or (iii) a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

The word **"birthday"** refers only to the month and day in a calendar year; not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first.

If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

1. The plan of the custodial parent pays first;
2. The plan of the spouse of the custodial parent pays second;
3. The plan of the non-custodial parent pays third; and
4. The plan of the spouse of the non-custodial parent pays last.

If your eligible dependent child is employed and becomes eligible for other group health coverage, the plan (other than this Plan) under which s/he is an Employee will be considered the primary plan for coverage. This Plan will pay secondary in the coordination of benefit payments.

Rule 3: Active/Laid-Off or Retired Employee

The plan that covers a person either as an eligible Employee or as that active Employee's dependent pays first; and the plan that covers the same person as a retired Employee, or retired Employee's dependent, pays second.

If a person is covered as retired Employee under one plan and as a dependent of an active Employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an Employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered other than as a dependent (that is, as an Employee, former Employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active Employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determine the order of benefits, the plan that covered the person for the longer period of time pays first, and the plan that covered the person for the shorter period of time pays second.

The start of a new plan does **not** include a change:

1. In the amount or scope of a plan's benefits.
2. In the entity that pays, provides or administers the plan.
3. From one type of plan to another (such as from a single Employer plan to a multiple Employer plan).

The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

How Much This Plan Pays When It Is Secondary

When this Plan pays second, it will pay the same benefits that it would have paid had it paid first, **less** whatever payments were actually made by the plan (or plans) that were primary (subject to the rule regarding your eligible dependent's obligation to utilize the "other plan's" mandatory programs, such as utilization review programs). In addition, when this Plan pays second, it will never pay more in benefits than it would have paid for each claim as it is submitted had it been the plan that paid first. This has the effect of maintaining this Plan's copayments, coinsurance, and exclusion provisions. 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.

Administration of COB

To administer COB, the Plan reserves the right to:

1. Exchange information with other plans involved in paying claims.
2. Require that you or your health care provider furnish any necessary information.
3. Reimburse any plan that made payments this Plan should have made.
4. Recover any overpayment from your Hospital, Physician, Dentist, other health care provider, other insurance company, you or your eligible dependent.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount that the Fund Office or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the medical and/or dental expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

If this Plan is secondary, this Plan will pay secondary medical benefits only when the coordinating primary plan pays medical benefits, and it will pay secondary dental benefits only when the primary plan pays dental benefits.

If this Plan is secondary, and if the coordinating primary plan provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the Allowable Expense and the benefits paid by the primary plan.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained outside of an exclusive network of providers, like an HMO, or otherwise reduced by a noncompliance penalty, this Plan will only consider such charges after reducing such charges by what the primary plan would have paid if not reduced by such penalties.

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 it always applies the "Gender Rule" in lieu of the "Birthday Rule", or because it does not use the same order of benefit determination rules as this Plan, this Plan may pay one-half of the benefits it would have paid had it been the primary plan expecting the other plan to pay the other half of the expenses.

COORDINATION OF BENEFITS WITH MEDICARE AND OTHER GOVERNMENT PROGRAMS

Medicare

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.

If you, your eligible dependent spouse and/or your eligible dependent child are covered by this Plan and by Medicare, and you remain active eligibility, your health care coverage will continue to provide the same benefits and this Plan pays first and Medicare pays second.

If you cancel your coverage under this Plan, coverage of your eligible dependent spouse and/or your eligible dependent child(ren) will terminate, but they may be entitled to COBRA continuation coverage. **See Section 22 for further information about COBRA continuation coverage.**

If you become totally disabled and entitled to Medicare because of your disability, you will continue to maintain your active coverage until your Administrative Account runs out. You will then have the option to continue coverage under COBRA.

If you are retired and eligible for coverage under Medicare, your active Plan coverage may be maintained until your Administrative Account runs out. You can utilize your HRA to self-pay for the Plan coverage offered by the Health Fund.

If while you are actively employed, you or any of your eligible dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first, and Medicare pays second for 30 months starting the **earlier** of: (1) the month in which Medicare ESRD coverage begins; or (2) the first month in which the individual receives a kidney transplant.

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

Medicare Advantage Programs

If you choose a Medicare Advantage Program (also referred as Medicare Part C, Medical Replacement Program, or Medicare Risk Program), you agree that no claim will be submitted to or paid by Medicare for health care services and/or supplies. There is no Coordination of Benefits between this plan and a Medicare Advantage Program.

Medicaid

For purposes of coordinating with Medicaid, this Plan will assume primary payor status for any Covered Person who is entitled to benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid), unless otherwise required by applicable law. Payment for benefits with respect to a Covered Person will be made in accordance with any assignment of rights made by or on behalf of such Covered Person as required by Medicaid under Section 1912(a)(1)(A) of the Social Security Act, 42 U.S.C. 1396k(a)(1)(A). If this Plan has the legal obligation to pay benefits and payment has been made under Medicaid, payment for benefits under this Plan will be made in accordance with state Medicaid law, which provides that the state acquires the rights of the Covered Person for payment of such benefits. The provisions of Section 1908 of the Social Security Act apply to the extent such provisions are in accordance with state Medicaid law.

Veterans Affairs Facility Services

If a Covered Person receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related Illness or Injury, benefits are not payable by the Plan.

If a Covered Person receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related Illness or Injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Reasonable and Customary.

Other Coverage Provided by State or Federal Law

If you 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 this Plan pays second.

Motor Vehicle No-fault Coverage Required by Law

If you or your eligible dependent is involved in an automobile accident and you are required by state law to have basic reparation coverage, your insurance carrier will be primarily liable for lost wages, medical, surgical, Hospital, and related charges.

Regardless of whether this Plan is primary or secondary, you or your eligible dependent (if an adult), must sign a Reimbursement Agreement (see Section 21) before any claims relating to the accident will be paid. The Reimbursement Agreement permits the Fund to receive reimbursement for expenses paid by the Fund that you recover through litigation or settlement with another party or insurance company.

Medicare Enrollment

If you are an active Participant, Part A coverage under Medicare is not automatic when you reach age 65 unless you have applied for Social Security Benefits. Since Part A coverage is not automatic, you and your spouse MUST register with Social Security for Part A when you reach age 65. You do not have to apply for Social Security payments (that is, actually retire), but you must apply and establish your entitlement to such benefits in order to be covered by Medicare.

You should also enroll in Part B during the seven-month period beginning three months before and ending three months after your 65th birthday. Failure to apply for Medicare coverage under Part B when you are eligible to do so could result in a higher cost to you for Medicare Part B Coverage when you finally apply. You should contact the Social Security Administration when you are approaching age 65 to obtain enrollment information specific to your situation.

19. FILING AND PROCESSING A CLAIM

This Section of the booklet describes the procedures for filing claims for benefits from the Heat and Frost Insulators Local No 33 Health Fund (the "Plan"). It also describes the procedures for you to follow if your claim is denied in whole or in part, and your wish to appeal the decision.

DEFINITIONS OF TERMS USED IN THIS SECTION (ALSO SEE DEFINITIONS, SECTION 23)

Adverse Benefit Determination means any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan.

Claim means a request for a benefit made by a claimant in accordance with the Fund's reasonable procedures. Casual inquiries about benefits or the circumstances under which benefits might be paid according to the terms of Plan are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, if a claimant files a Claim for specific benefits and the Claim is denied because the individual is not eligible for benefits under the Plan, the coverage determination is considered a Claim. A request for prior approval of a benefit that does not require prior approval by the Plan is not considered a Claim. However, requests for prior approval of a benefit where the Plan does require prior approval (e.g., Hospital pre-admission certification, etc.) are considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described in the claim procedures below.

Concurrent Claim means a Claim that is reconsidered after an initial approval is made, resulting in a reduction, termination, or extension of a benefit. (An example of this type of claim would be an inpatient Hospital stay originally certified for five (5) days that is reviewed at three (3) days to determine if the full five days stay is still appropriate. In this situation, a decision to reduce, terminate, or extend the Hospital stay is made concurrently with the period of Hospitalization).

Disability Claim means a Claim that requires a finding of total disability as a condition of eligibility. This includes Claims for Disability Income Benefits.

Post-Service Claim means a Claim for benefits that is not a Pre-Service, Concurrent, or Urgent Claim. Specifically, a claim submitted for payment *after* health services or treatment has been obtained.

Pre-Service Claim means a Claim for a benefit for which the Plan requires approval before health care is obtained or approval is required in order to receive the maximum benefit provided by the Plan.

Urgent Claim means a Claim for health care or treatment that if normal Pre-Service standards were applied, would seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, subject the Covered Person to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

HOW TO FILE A CLAIM

As stated earlier in this Section, a claim for benefits is a request for Plan benefits made in accordance with the Plan's claims procedures.

Network Benefits

If you use network providers, for example, through the Anthem Blue Cross/Blue Shield of Connecticut Preferred Provider Organization (PPO), your claim for benefits will go directly from your network health care provider (Hospital, Physician, laboratory etc.) through an automated electronic system that ultimately delivers to Insurance Programmers, Inc. (IPI) for processing. Generally, you are not required to file a claim form for in-network benefits.

Out-of-Network Benefits

If you use out-of-network providers not affiliated with Blue Cross/Blue Shield, you must submit a completed claim form and follow the claims procedures outlined in this Section, as applicable. You can obtain claim forms from the Fund Office or IPI. You can obtain a claim form by calling IPI at 800-446-8646.

The following information must be completed on the claim form in order for your request for benefits to be considered a Claim, and for the Plan to be able to process your claim.

You complete the Employee portion of the claim form, as follows:

- Participant name.
- Patient name.
- Patient Date of Birth.
- Fund Identification number of the active Participant.

Your Physician (or other provider) may either:

1. **Complete the following items, as applicable, on the Attending Physician's Statement section of the claim form:**
   - Date of Service.
   - CPT-4 (the code for Physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association).
   - ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services).
   - Billed charge.
   - Number of Units (for anesthesia and certain other claims).
   - Federal taxpayer identification number (TIN) of the provider.
   - Billing name and address.
   - If treatment is due to accident, accident details.

OR

2. **Attach all itemized bills or doctor's statements that describe in full the services rendered.**

NOTE: *Urgent Hospital or medical claims and appeals must be submitted by making a telephone call to Hines & Associates, the Fund's Utilization Review company (see Section 7) and followed up in writing within 24 hours with the information listed above.*

WHERE TO FILE A CLAIM OR APPEAL

Claims for benefits or appeals of denied claims should be submitted as follows:

Weekly Disability Benefit Claims:

Claims: The Fund Office
Heat and Frost Insulators
Local No. 33 Health Fund
618 South Colony Road
Wallingford, CT 06492
203-265-6673

Appeals: The Fund Office

Life Insurance and Accidental Death and Dismemberment Coverage:

Claims: The Fund Office
Heat and Frost Insulators
Local No. 33 Health Fund
618 South Colony Road
Wallingford, CT 06492
203-265-6673

Appeals: The Fund Office

All Medical Coverage (except for Prior-Authorization, and claims secondary to Medicare):

In network claims are submitted electronically through Anthem BC/BS. Out-of-Network claims should be submitted to:

Insurance Programmers, Inc.
P.O. Box 5817
Wallingford, CT 06492
1-800-446-8646

Appeals: Insurance Programmers, Inc.

Prior-Authorization:

Claims: Hines & Associates, Inc.
115 E. Highland Avenue
Elgin, IL 60120
1-800-944-9401

Dental Coverage:

Claims: The Fund Office
Heat and Frost Insulators
Local No. 33 Health Fund
618 South Colony Road
Wallingford, CT 06492
203-265-6673

Appeals: Delta Dental Plan of New Jersey, Inc.,
Customer Service Department
P.O. Box 222
Parsippany, NJ 07054-0222
1-800-452-9310

Mental Health and Substance Use Disorder Coverage:

In network claims are submitted electronically through Anthem BC/BS. Out-of-Network claims should be submitted to:

Insurance Programmers, Inc.
P.O. Box 5817
Wallingford, CT 06492
1-800-446-8646

Appeals: Insurance Programmers, Inc.

Prescription Drug Coverage:

Retail Pharmacy

Claims: You are not required to submit a claim form when visiting a participating Pharmacy. Simply present your Fund Rx (prescription drug) identification card to a retail Pharmacy with your prescription to the pharmacist. When you present a prescription to a Pharmacy to be filled, that request is not a "claim" under the Plan's procedures. However, if the Pharmacy rejects your request to fill a prescription covered by the Plan, in whole or in part, you may file a claim by contacting the Fund Office.

Appeals: OptumRx Appeals
CA106-0286
3515 Harbor Boulevard
Costa Mesa, CA 92626
1-888-403-3398
Fax: 1-866-308-6294 (Standard) or 1-866-308-6296 (Expedited)

Mail Order Pharmacy

Appeals: OptumRx Appeals

Vision Benefits:

Claims: Vision benefits are provided through Davis Vision. When you use a Davis Vision network provider, your claim will automatically be sent to Davis Vision by the optometrist. There are no claim forms to complete.

Out-of-Network Claims:

Call or access Davis Vision's website to obtain a claim form: www.davisvision.com
Davis Vision, Inc.
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110
1-800-999-5431

Appeals: Davis Vision, Inc.
159 Express Street
Plainview, NY 11803

Hearing Benefits:

Claims: Hearing benefits are only provided through the University of Connecticut Speech and Hearing Clinic. You can schedule an appointment at The University of Connecticut Speech and Hearing Clinic in Storrs, Connecticut, at 860-486-2629. You can call the Hearing Clinic directly or contact the Fund Office for assistance in scheduling an appointment at the Hearing Clinic. All claims are processed directly by IPI. There are no claim forms to complete.

Appeals: Insurance Programmers, Inc.

NOTE: *If you ever need assistance determining where your claim or appeal should be sent, contact the Fund Office.*

Voluntary Appeals: After a Participant has exhausted the initial appeal with Hines & Associates, a voluntary level of appeal to the Board of Trustees is available. All requests for a voluntary appeal of denied benefits should be directed to the IPI for all benefits coverage.

Health Reimbursement Account:

Claims: Insurance Programmers, Inc.—Indicate the date of service, the provider, and the amount you are requesting be reimbursed.

When Claims Must Be Filed

Claims should be filed with all the information necessary to be processed as soon as reasonably possible following the date the services or treatment was received and the charges incurred. Stricter filing rules apply to pre-service claims and urgent care claims. If a Claim is not received by the Fund Office within **15 months** after it is incurred, the claim will be denied on the basis that it has not been filed in a timely manner. This includes the failure to provide information requested to process the claim including accident reports, etc.

The incurred date for an inpatient Hospital claim is the admission date. For all other medical and vision claims, it is the date treatment is received.

The incurred date for Disability Claims is the first (1st) day of disability due to Injury or the eighth (8th) day of disability due to Illness measured from the date you first lose time from work and are treated by a Physician because of the disability. The incurred date for a Life Insurance claim is the date of death.

REMEMBER: All claims for benefits must be submitted with all the information necessary to be processed absolutely no later than 15 months from the date the charges were incurred or the claim will not be paid. The Board of Trustees may, under the voluntary appeal provision, consider claims received after this deadline only if substantiating evidence documents the delay was caused by the service provider or primary insurance carrier.

Authorized Representatives

An authorized representative, such as your spouse or adult child, may submit a claim on your behalf if you are unable to do so yourself and you have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office or IPI 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 Claim without you having to complete an authorization form.

HEALTH CARE CLAIMS PROCEDURES

The claims procedures for your health care benefits will vary depending on whether your claim is for a **Pre-Service Claim**, an **Urgent Claim**, a **Concurrent Claim**, a **Post-Service Claim**, or a **Disability Claim** as follows:

Pre-Service Claim Procedures

As indicated, a Pre-Service Claim is a Claim for a benefit for which the Plan requires approval **before** health care is obtained or full payment from the Plan will not be made. The Plan has hired an independent health benefits administrator, Hines & Associates, to conduct pre-certifications of Pre-Service Claims for medical care and mental health care to determine their eligibility for payment before treatment is received.

A pre-certification, approved by Hines & Associates, is required for each of the Pre-Service Claims listed below:

- Inpatient Hospital Admission for medical treatment.
- Inpatient Mental Health or Alcohol/Substance Use Disorder Treatment.
- Inpatient Surgery.
- Outpatient Surgery.
- Home Health Care.
- Hospice Care.

Steps to take for Pre-certification:

For Pre-Service Claims you must call Hines & Associates first at 1-800-944-9401.

For properly filed Pre-Service Claims, you will be notified of a decision within 15 days from receipt of the Claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of Hines & Associates. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because Hines & Associates needs additional information from you, you will be notified before the end of the initial 15-day period of the information needed. You (or your doctor) will then have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the period in which you are allowed to supply the additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until the earlier of 45 days or the date you respond to the request. Once all the information requested is received, there is a 15-day grace period to make a decision on the Claim and notify you of its determination.

If you improperly file a Pre-Service Claim, you will be notified as soon as possible but not later than 5 days after receipt of the claim, of the proper procedures to be followed in filing a Claim. You will only receive notice of an improperly filed Pre-Service Claim if there is sufficient information to identify the Participant and respond to the request.

Unless the claim is re-filed properly, it will *not* constitute a Claim.

Urgent Claim Procedures

Urgent Claims for Hospital, medical, mental health or substance use disorder treatment must be submitted to Hines & Associates by calling 1-800-944-9401.

NOTE: *If you or your eligible dependent is confined to a Hospital on an emergency basis, you, your Authorized Representative, a responsible family member, the attending Physician or the Hospital must call Hines & Associates no later than 48 hours after admission or, if a weekend or holiday admission, the next business day at 1-800-944-9401 notifying Hines & Associates' representative of the confinement and providing the information required to establish an approved Hospital stay. See Section 7, Utilization Review Program, for further details.*

Hines & Associates will determine whether a Claim is an Urgent Claim by applying the judgment of a prudent individual with average knowledge of health and medicine. Alternatively, if a Physician with knowledge of the patient's medical condition determines that the Claim is an Urgent Claim, and notifies Hines & Associates of such, it will be treated as an Urgent Claim.

Hines & Associates will respond to you or your authorized representative if applicable, with a determination of your claim by telephone as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claim by Hines & Associates. The determination will also be confirmed in writing.

If an Urgent Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, Hines & Associates will notify you as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. You must provide the specified information within 48 hours. If the information is not provided to Hines & Associates within that time, the Claim will be denied.

Notice of the Claim decision will be provided to you no later than 48 hours after Hines & Associates receives the specified information, or the end of the 48-hour period given for you to provide this information, whichever is earlier.

If you improperly file an Urgent Claim, Hines & Associates will notify you, or your authorized representative, if applicable, as soon as possible, but not later than 24 hours after receipt of the Claim, of the proper procedures to be followed in filing a Claim. Unless the claim is re-filed properly, it will not constitute a Claim.

With respect to an Urgent Claim, a health care professional with knowledge of the Covered Person's medical condition will be permitted to act as an authorized representative.

Concurrent Claim Procedures

Reconsideration of a Hospital or medical Concurrent Claim that involves the termination or reduction of a previously approved benefit (other than by Plan amendment or termination) will be made by Hines & Associates as soon as possible. In any event, the Covered Person will be given enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated. See Section 20, *Denial of Claims and Procedures for Appeal*, for information on how to file an appeal of a Concurrent Claim.

Any request by a claimant to *extend* an approved Urgent Claim will be acted upon by Hines & Associates within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to extend approved treatment that does not involve an Urgent Claim will be decided according to the guidelines for Pre-Service or Post-Service Claims, as applicable.

Post-Service Claim Procedures

To have your Post-Service Claim processed, you will be required to submit a completed claim form for out-of-network medical claims and you may be required to submit a claim form for dental expenses. A new completed claim form is also required for a new Injury or Illness and may be required at any time before a claim will be processed. To assure processing without a delay, you should always submit a completed claim form with any Post-Service expenses.

REMEMBER: IF YOU DO NOT SUBMIT A COMPLETED CLAIM FORM WITH ALL THE NECESSARY INFORMATION TO PROCESS A POST-SERVICE CLAIM WITHIN 15 MONTHS FROM THE DATE SERVICES WERE PROVIDED, THE CLAIM WILL NOT BE PAID.

All Post-Service Claims should be submitted to the Fund Office as soon as possible after the date the service or treatment is received.

In order for a request for benefits to be considered a Post-Service Claim, and to avoid a delay in benefit payments, it is important that you provide the following information with each claim submitted:

1. If there is more than one group health plan involved, your claim must be submitted in accordance with the Coordination of Benefits procedures described in Section 18.

2. A separate claim form must be submitted for out-of-network claims for each Covered Person who incurs Covered Charges. Claim forms may be obtained at the Fund Office. A separate claim form must be submitted for each claim.

3. ALL questions must be completed and answered on the Participant's portion of the claim form.

4. The claim form must be signed by the Participant or eligible dependent spouse, if applicable.

5. The Physician's (or other provider's) portion of the claim form must be completed by the Physician (or other provider). However, an original or carbon copy of an itemized bill from a Physician or other provider, which includes all of the supporting information as requested on the claim form, will be acceptable. This itemized bill must be securely attached to the claim form and should include the following information:
   - Patient's full name.
   - Date of service.
   - Description of the service or CPT-4 code(s).
   - Diagnosis or ICD-9 code(s).
   - Itemized charges.
   - Number of units (for anesthesia and certain other claims).
   - Provider's federal taxpayer identification number (TIN).
   - Provider's billing name and address.

Ordinarily, you will be notified of decisions on Post-Service Claims within 30 days from the date the Claim was received at the Fund Office. This period may be extended one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund Office. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Fund expects to render a decision.

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

If the Fund Office determines that additional information is required, the Fund Office may issue a combined request for additional information and notice of adverse benefit determination. The notice of adverse benefit determination would only be applicable if the claimant fails to provide any information within 45 days. In this case, the Fund Office would not issue a separate notice of adverse benefit determination if you fail to submit any information within 45 days. The combined notice will clearly state that the Claim will be denied if you fail to submit any information in response to the Fund's request, and will satisfy the requirements of both a request for additional information and the notice of adverse benefit determination under the Plan. When the combined notice is used, the timeframe for appealing the adverse benefit determination begins to run at the end of the 45-day period prescribed in the combined notice for submitting the requested information.

Disability Claims Procedures

Disability Income Benefit Claims should be submitted to the Fund Office as soon as practicable after the date of disability. The "date of disability" is the first (1st) day of disability due to an Injury, and the eighth (8th) day from the date you first lose time from work and are treated by a Physician because of disability due to an Illness.

Claims must be received at the Fund Office within 15 months of the onset of the disability to be considered "on time" for processing.

Disability Claims must be submitted to the Fund Office in writing, using the appropriate application form. An application form may be obtained by contacting IPI at 1-800-446-8646.

The Fund will make a decision on the Claim and notify the claimant of the decision within 45 days. If the Fund Office requires an extension of time due to matters beyond its control, it will notify the claimant of the reason for the delay and indicate 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 from the time the Fund Office notifies the claimant of the delay. The period for making a decision may be delayed an additional 30 days, provided the Fund Office notifies the claimant prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date as of which the Fund expects to render a decision.

If an extension is needed because the Fund Office needs additional information from the claimant, the extension notice will specify the information needed. In that case, the claimant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45-day period in which the claimant is allowed to supply additional information, the normal deadline for

making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date the claimant responds to the request (whichever is earlier). Once the claimant responds to the request for information, he or she will be notified of the decision on the Claim within 30 days.

Life Insurance and Accidental Death and Dismemberment Claims

Claims for Life Insurance or Accidental Death and Dismemberment benefits should be filed with the Fund Office.

Like your other benefits, these claims should be filed with all the information necessary for processing, as soon as reasonably possible, following the date of death or accident resulting in a covered Injury. Claims must be submitted within 15-months to be considered filed in a timely manner.

Notice of Initial Benefit Determination (Hospital, Medical, Dental Prescription Drugs, Vision, Hearing and Disability Income Benefit Claims)

You will be provided with written notice of the initial benefit determination of your claim. If your claim is *denied*, in whole or in part, an "Adverse Benefit Determination" notice will include:

1. Include information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable).
2. The specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim.
3. Reference to the specific Plan provision(s) as described in this booklet on which the determination is based.
4. A description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary.
5. A description of the Plan's internal appeal procedures (including voluntary appeals) and external review processes, including applicable time limits and information on how to initiate an appeal.
6. If an internal rule, guideline or protocol was relied upon in deciding the Claim, a copy is available upon request at no charge.
7. If the determination was based on the absence of Medical Necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.
8. For Urgent Claims, a description of the expedited review process applicable to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification).
9. A statement of the claimant's right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination.

In addition, other than for Disability Income benefit claims, the notice will disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with their internal claims and appeals and external review processes. The Plan will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial of appeal is required to be

provided to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan can deny your claim on appeal based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial on appeal is required to be provided to give you a reasonable opportunity to respond prior to that date.

Payment of Hospital and Physicians' Bills

As previously noted, if you use a network provider (Anthem Blue Cross/Blue Shield of Connecticut), your claim for benefits will go directly from your network health care provider (Hospital, Physician, or facility) electronically through Anthem and ultimately to Insurance Programmers, Inc. for processing. The Health Fund, by contract with Anthem, will pay the health care provider directly. The same is true for OptumRx for Pharmacy claims, Davis Vision for vision claims and the University of Connecticut Speech and Hearing Clinic for hearing benefits.

If you use a non-network provider, payment of Hospital bills will be made directly to the Hospital only if you sign the appropriate authorization statement on the claim form from the Hospital. Payment of bills from Physicians and other providers will normally be made directly to you, unless you assign the benefit by signing the line on the claim form that indicates your request that benefits be paid directly to the provider of service.

Even though the Fund may make payment of claims on behalf of a Covered Person to the provider directly, no provider will have any right, title, or interest to payment from the Fund, and no provider will have a right to any remedies or other procedures provided under the Plan for the benefit of a Covered Person. **Only the Covered Person may exercise any rights provided under this Plan and any assignment, pledge or other agreement between the Covered Person and any provider will not create any rights against this Plan and any such assignment, pledge or other agreement will be null and void as to this Plan.**

Disputes About Hospital and/or Physicians' Bills

Occasionally, a claim processor will question the amount or the reasonableness of a billing and whenever the amount or reasonableness of a charge is questioned, the claims processor may investigate the matter. If the dispute cannot be resolved, the Fund Office will first rely on Hines & Associates for guidance. In some matters, under the voluntary appeal procedures, the Board of Trustees may retain the services of an independent professional medical peer review organization with the appropriate medical expertise to determine the Fund's obligation under the Plan for those charges. The Fund will reimburse only Covered Charges, to the extent that the peer review organization's evaluation supports the charges and/or services as reasonable, customary, and proper.

No Medical Examination or Age Restriction

No medical examination is required of any person to become eligible for Fund benefits and all new Participants and eligible dependents will be covered.

Notice of Life Insurance or Accidental Death and Dismemberment Insurance Determination

For Life Insurance and/or Accidental Death and Dismemberment Insurance Claims, the insurance carrier, Prudential, will make a decision and notify your beneficiary (or you) of its decision within 90 days. However, if Prudential requires an extension of time due to matters beyond its control, it will notify your beneficiary (or you) of the reason for the delay and when the decision will be made. The extension will not exceed 90 days.

20. DENIAL OF CLAIMS AND PROCEDURES FOR APPEAL

APPEALING AN ADVERSE BENEFIT DETERMINATION

If your Claim is denied in whole or in part, or if you disagree with the decision made on a Claim, you may appeal the decision.

Post-Service and Disability Claims

Appeals of Adverse Benefit Determinations regarding Post-Service Claims and Disability Claims must be submitted in writing **within 180 days** after receipt of the Notice of Adverse Benefit Determination and must include:

1. The patient's/member's name and address.
2. The claimant's name and address, if different.
3. A statement that this is an appeal of a decision by the Board of Trustees.
4. The date of the Adverse Benefit Determination.
5. The basis of the appeal i.e., the reason(s) why the Claim should not be denied.

Life Insurance and Accidental Death and Dismemberment Insurance

Appeals of Adverse Benefit Determinations regarding Life Insurance and/or Accidental Death and Dismemberment Claims must be submitted in writing **within 60 days** after receipt of the Notice of Adverse Benefit Determination and must include the same information noted immediately above.

Appeals should be sent to Prudential with a copy to the Fund Office, refer to page 19-3.

Urgent and Pre-Service (Prior Authorization) Claims

Appeals of Adverse Benefit Determinations regarding Urgent Claims and Pre-Service Claims may be made orally within 180 days after receipt of the notice of Adverse Benefit Determination.

- For medical claims, call Hines & Associates at 1-800-944-9401.
- For dental claims, call the Delta Dental at 1-800-452-9310.
- For vision claims, call Davis Vision at 1-800-999-5431.

Concurrent Claims

Appeals of Adverse Benefit Determinations regarding Concurrent Claims may be made orally by calling Hines & Associates. For a Concurrent Claim that involves a termination or reduction of previously approved care, there is no set timeframe for filing an appeal however, the appeal must be completed before the care is terminated or reduced. For a Concurrent Claim regarding an extension of care, the appeal timeframe will be the timeframe for an Urgent, Pre-Service, or Post-Service Claim, whichever category applies to your appeal.

See pages 19-3, 19-4, and 19-5 for more information about where to file an appeal of a denied Claim

INTERNAL APPEALS PROCESS

The internal appeals process works as follows:

You will have the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was submitted or considered as part of the initial benefit determination.

Also, you will be provided with reasonable access to and copies of all Relevant Documents pertaining to your Claim upon request and free of charge. The term "Relevant Documents" means documents pertaining to a Claim if:

1. They were relied upon in making the benefit determination.
2. They were submitted, considered or generated in the course of making the benefit determination (regardless of whether they were relied upon).
3. They demonstrate compliance with the Plan's administrative processes and safeguards for ensuring consistent decision-making.
4. They constitute the Plan's policy or guidance with respect to the denied treatment option or benefit.

Relevant Documents could include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Plan's rules were appropriately applied to a Claim.

A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not give deference to the initial Adverse Benefit Determination. The reviewer's decision will be made on the basis of the record, including such additional documents and comments that may be submitted by the claimant.

If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary or was Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine and who is neither an individual who was consulted in connection with the initial denial nor a subordinate of any such individual, will be consulted.

For Life Insurance and/or Accidental Death and Dismemberment Claims, the process works similarly. You will have the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was submitted or considered as part of the initial benefit determination. In addition, you will be provided upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to your Claim.

TIMEFRAMES FOR NOTICES OF APPEAL DETERMINATIONS

Pre-Service Claims

Notice of the appeal determination for Pre-Service Claims will be sent within 30 days of receipt of the appeal by Hines & Associates.

Urgent Claims

Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal by Hines & Associates.

Concurrent Claims

Notice of the appeal determination for a Concurrent Claim that involves a termination or reduction of previously approved care will be sent by Hines & Associates before the care is terminated or reduced. Notice of the appeal determination for a Concurrent Claim that involves an extension of care will be sent by Hines & Associates based on the timeframes for an Urgent, Pre-Service, or Post-Service Claim, whichever category applies to the appeal.

Post-Service Claims

Notice of the appeal determination for a Post-Service Claim will be sent within 60 days of receipt of the appeal by the claims administrator.

Disability Claims

Ordinarily, decisions on appeals involving Disability Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the request for appeal. However, if the request is received within 30 days of the next regularly scheduled meeting, it will be considered at the second regularly scheduled meeting following receipt of the appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the appeal may be necessary. The claimant will be advised in writing in advance if this extension will be necessary. Once a decision on the appeal has been reached, notice of the appeal determination will be sent as soon as possible, but no later than 5 days after the decision has been reached.

Life Insurance and/or Accidental Death and Dismemberment Claims

Notice of the appeal determination for will be sent within 60 days after receipt of the appeal by Prudential, unless an extension of time is needed to properly adjudicate your Claim. If such an extension is needed, notice of the appeal determination will be sent no later than 120 days after Prudential received the appeal.

CONTENT OF APPEAL DETERMINATION NOTICES (HEALTH CARE AND DISABILITY CLAIMS)

The determination of an appeal will be provided to you in writing. If denied, the notice of a denial of an appeal will include:

1. Identification of the claim involved, including date of service, provider, claim amount, and a statement with denial codes and their respective meanings;
2. The specific reason(s) for the determination.
3. Reference to the specific Plan provision(s) as described in this booklet on which the determination is based.
4. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to the Claim upon request and free of charge.
5. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal.
6. A description of the Plan's voluntary appeal procedures available.
7. If an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon request at no charge.

8. If the determination was based on Medical Necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.
9. Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with internal claims and appeals and external review processes for external claims; and
10. The following statement: "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

NOTE: *In addition, other than for Disability Income claims, the Plan will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial of the appeal is required to be provided to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan can issue a denial on appeal based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial on appeal is required to be provided to give you a reasonable opportunity to respond prior to that date.*

VOLUNTARY APPEALS (Not applicable to Life and AD&D claims)

If you are notified that your appeal of a denied claim for benefits was rejected (*i.e.,* you receive an Adverse Benefit Determination regarding your appeal), you may file a voluntary appeal with the Board of Trustees if you choose to do so. Subject to verification procedures as the Plan may establish, your Authorized Representative (cannot be a provider) may act on your behalf in filing and pursuing this voluntary appeal. All of the corresponding levels of claims and appeals previously described in this Section must be fully completed before you can file a voluntary appeal. Your voluntary appeal must be filed with the Trustees for their final review within 60 days after you receive an Adverse Benefit Determination under the standard appeal process described above.

If you elect to file a voluntary appeal, any applicable statute of limitations or any other defense based on timeliness will be tolled ("suspended") while your appeal is pending. The filing of a voluntary appeal will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action. If you choose not to file a voluntary appeal, the Plan will not assert that you failed to exhaust your administrative remedies because of that choice. No fees or costs will be imposed upon you by the Plan as part of the voluntary level of appeal. Also, your decision to submit a prior denial of benefits to the Board of Trustees as part of your voluntary appeal will have no effect on your rights to any other benefits under the Plan.

If you choose to file a voluntary appeal with to the Board of Trustees, you must do so in writing. You should send the following information:

1. The specific reason(s) for the appeal.
2. Copies of all past correspondence with the Plan and the claims administrator regarding the benefit claim, including the Explanation of Benefits (EOBs) you received.
3. Any other applicable or new relevant information you have not yet submitted regarding the benefit claim.

If you file a voluntary appeal, you will be deemed to have authorized the Board of Trustees to obtain any and all relevant information regarding your claim from the Plan. Mail your written voluntary appeal directly to:

Board of Trustees
Heat and Frost Insulators Local No. 33 Health Fund
P.O. Box 5817
Wallingford, CT 06492-7617
1-800-446-8646

The Trustees will review your appeal within the timeframes previously described relating to eligibility decisions and will notify you in writing of their final determination regarding your voluntary appeal.

Appeals of Dental Claims

Delta Dental will notify you if any services are denied, in whole or in part, stating the reason(s) for the denial, references to pertinent sections, additional information you must provide to improve your claim and the procedure available for further review of your claim on a *Notification of Delta Dental Benefits*, which will be sent to you. Within 60 days after receipt of a notice of denial, you may make a written request for review of such denial by addressing your request to Delta Dental Plan of New Jersey, Inc., Customer Service Department, P.O. Box 222, Parsippany, NJ 07054-0222. You must state the reason(s) you believe Delta Dental should reconsider its determination of benefits.

You must also provide:

1. The name(s) and address(es) of the subscriber(s) and the patient(s).
2. Your Social Security number.
3. The claim number(s) you request to be reviewed.
4. The name of the Dentist.
5. The date(s) of the service(s).
6. Detailed description as to the basis of your appeal.

You must include any additional information or documentation, which you believe, may support your claim(s). Before making a formal written request for review, you are encouraged to discuss your claim with your plan administrator.

Delta Dental may require additional information for its review. Certain review requests may be referred to one of Delta Dental's consultants. Unless referral to a consultant is required or other unusual circumstances arise, you should receive a written decision on your request for review within 30 days but no longer than 60 days after Delta Dental receives your request. If special circumstances require an extension of time, a written notice of the extension will be sent to you and a decision will be made no later than 120 days after the receipt of the review. Notification of the decision will be clearly described and will specify the reasons for the decision.

DECISION FINAL AND BINDING

A decision on review of any Claim made under the Plan in accordance with the above procedures will be considered final and binding on all persons.

LIMITATION ON WHEN A LAWSUIT OR EXTERNAL REVIEW MAY BE STARTED

You may **not** seek external review or start a lawsuit to obtain benefits until after you have requested an appeal and a final decision has been reached on the appeal, or until the appropriate timeframe described above has elapsed since you filed an appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision. However, 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 (3) years after the end of the year in which the health care services were provided, or if a claim is for disability benefits, more than three (3) years after the start of the disability.

EXTERNAL REVIEW OF HEALTH CARE CLAIMS (Does not apply to Disability Income or Life Insurance claims)

This External Review process is intended to comply with the Affordable Care Act's external review requirements.

If you are not literate in English, depending on the county in which you reside, you may be eligible for assistance in the non-English language in which you are literate. Call the IPI at (800) 446-8646 for more information.

If your appeal of a claim is denied, whether it's a pre-service, post-service, or urgent care claim, you may request further review by an independent review organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

NOTE: *External review is only available for the following types of denials of claims:*

- A denial that involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and
- A denial due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan.

External Review of Hospital, Medical, Mental Health/Substance Use Disorder, Prescription Drug, Dental, Hearing and Vision Claims (Only)

Your request for external review of a denial must be made, in writing, within four (4) months of the date that you receive the denial. Because the Plan's internal review and appeals process generally must be exhausted before external review is available, typically external review of claims will only be available for denials of appeals (and not initial claim denials).

1. Preliminary Review

   (a) Within five (5) business days of the Plan's receipt of your external review request for a claim, the Plan will complete a preliminary review of the request to determine whether:

   - You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
   - The denial does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;

- You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances); and
- You have provided all of the information and forms required to process an external review.

(b) Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request meets the threshold requirements for external review. If applicable, this notification will inform you:

- If your request is complete and eligible for external review, or
- If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)), or
- If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

2. Review By Independent Review Organization

If the request is complete and eligible, the Plan will assign the request to an Independent Review Organization or "IRO." The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan has contracted with more than one IRO, and generally rotates assignment of external reviews among the IROs with which it contracts.

Once the claim is assigned to an IRO, the following procedure will apply:

(a) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days).

(b) Within five (5) business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its denial determination.

(c) If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its denial that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its denial, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional

information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s), unless such requirements are inconsistent with applicable law.

(e) The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.

(f) The assigned IRO's decision notice will contain the following information, unless such information is inconsistent with applicable current law:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist with external review processes.

Expedited External Review of Claims

You may request an expedited external review if:

- You receive an initial claim denial that involves a medical condition for which the timeframe for completion of a non-expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- You receive a denial from an appeal that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive a denial from an appeal that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Preliminary Review

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above, in Section 1(a), are met. The Plan will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above in Section 1(b).

Review By Independent Review Organization

Upon a determination that a request is eligible for expedited external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in denying the claim.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, above at Section 2. In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, unless such requirements are inconsistent with applicable law.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above in Section 2.(f), as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

After External Review

If, upon external review, the IRO reverses the Plan's denial, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

If the final external review upholds the Plan's denial, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

21. SUBROGATION

PAYMENT PRIOR TO DETERMINATION OF RESPONSIBILITY OF A THIRD PARTY

The Plan does not cover nor is it liable for any charges or expenses incurred by a Participant, his or her parent(s) and eligible dependent(s) or a representative, guardian or trustee of the Participant, parent(s) or eligible dependent(s) (hereinafter, collectively "claimant") as a result of an accident or Injury for which one or more third parties (any person or entity) are or may be liable. See Section 13 for Limitations and Exclusions.

However, subject to the terms and conditions of this Section, the Board of Trustees, at their discretion, may advance payment for some or all of a claimant's expenses, and may provide the Participant with disability income payments (if the Participant qualifies) after receipt of a properly executed Reimbursement Agreement and Consent to Lien. In addition, acknowledgement of the Agreement must be provided to the Fund Office by the claimant's attorney. The Reimbursement Agreement and Consent to Lien, and Acknowledgement must be executed without alteration or any other condition.

Where the Plan has made payments for an Injury, irrespective of any signed written agreement, the Plan will have the right to recover from the Participant the full amount of benefits paid without deductions or adjustments of any kind if the claimant obtains any settlement, judgment, arbitration or recovery from a third party or from any insurance provider or other source. In such event, the Plan will have a first lien on any such recovery and must be promptly reimbursed in full within 30 days or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees. The claimant will first reimburse the Fund out of any recovery before the claimant is entitled to any portion of the recovery and without regard to the extent of the recovery that has been or may be provided to the claimant.

As previously noted, the Plan has the right to recover the full amount of benefits paid by the Plan, without deductions or adjustments of any kind. For example, there is no deduction or adjustment for attorney's fees incurred by the claimant in obtaining the settlement, judgment, arbitration or recovery. The Plan's lien is not reduced by any such attorney's fees. Regardless of the sufficiency of any recovery, the Plan is not subject to any state law doctrines, including but not limited to, the common fund doctrine, which would purport to require the Plan to reduce its recovery by any portion of a Participant's attorney's fees and costs. The Plan is also not subject to the make whole doctrine or other similar doctrines which purport to subject the Plan's recovery to the claimant's full compensation for all of his injuries.

In the event the claimant fails to reimburse the Fund from proceeds received from a third party, the Fund will also have the right to withhold future benefits equal to the amount otherwise due the Fund, plus interest and the costs of collection including attorneys' fees.

REIMBURSEMENT AND CONSENT TO LIEN

Every claimant, on whose behalf an advance may be payable, must execute and deliver to the Fund a Reimbursement Agreement and Consent to Lien in the form provided without alteration. Claimants must do whatever is necessary to protect the Fund in obtaining reimbursement and/or its subrogation rights. Each such claimant must promptly notify the Fund Office if he/she makes a claim or brings an action against a third party.

If any claimant does not execute any such Reimbursement Agreement or Consent to Lien for any reason, it will **not** waive, compromise, diminish, release, or otherwise prejudice any of the Fund's reimbursement rights if the Fund at its discretion, makes an advance and inadvertently pays benefits in the absence of a reimbursement agreement.

The Fund's standard administrative procedure will be to determine whether a third party might potentially be held liable in connection with an accident or Injury. Claims will **not** be paid until this determination is made. If it is determined that the claim may be the result of a third party's negligence, or other misconduct, the Fund will not process any claims without a properly signed Reimbursement Agreement and Consent to Lien along with acknowledgement by the claimant's attorney, both executed without alteration or other condition.

COOPERATION WITH THE PLAN BY ALL COVERED PERSONS

By accepting an advance for related claim payment, every claimant agrees to do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Fund's reimbursement rights.

By accepting an advance payment for related claims to an Injury, every claimant agrees to notify and consult with the Board of Trustees, its Fund Office or designee before:

- Starting any legal action or administrative proceeding against a third party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the claimant's Injury that resulted in the Fund's advance payment of claims; or
- Entering into any settlement agreement with that third party or that third party's insurer that may be related to any actions by that third party that may have caused or contributed to the claimant's Injury that resulted in the Fund's advance for claims related to such Injury.

By accepting an advance in claim payments, every claimant agrees to keep the Board of Trustees, its Fund Office or designee, informed of all material developments with respect to all such claims, actions, or proceedings.

All Recovered Proceeds Are to Be Applied to Reimbursement of the Fund

By accepting an advance payment of claims for an Injury, every claimant agrees to reimburse the Fund for all such advances, by applying any and all amounts paid or payable to them by any third party or that third party's insurer by way of settlement, judgment, arbitration or recovery or in satisfaction of any judgment or agreement, regardless of whether those proceeds are characterized as being paid on account of the medical expenses for which any advance has been made by the Fund. The Fund will have the right to recover from the claimant the full amount of benefits paid without deductions or adjustments of any kind including attorney's fees. In such event, the Fund must be fully reimbursed within 30 days of the date proceeds are received by the claimant or his attorney, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees. The Fund may offset future claims/benefits in order to receive the full amount of benefits paid if full reimbursement is not made.

If any Covered Person fails to reimburse the Fund as required by this Section, the Fund will apply any future claims for benefits that may become payable on behalf of the claimant to the amount not reimbursed. The amount of the offset to future claims will be based without regard to the discounted amount paid by the Fund through its PPO network and therefore, your liability will be greater than the claims paid by the Fund. **For example, if you do not reimburse the Fund $10,000 of Hospital bills paid under the Plan, which you recovered in a lawsuit, the Fund will not pay future claims/benefits of approximately $20,000 considering the Fund's discounts of about 50%**.

Once a claim is settled, the Fund will not pay future benefits for claims related to the Injury or accident under Workers Compensation but may consider future benefits not related to Workers Compensation if it is determined by the Board of Trustees that the original settlement was reasonable and the subsequent claims were not recognized in the settlement.

THIS FUND IS A SELF-INSURED EMPLOYEE WELFARE BENEFIT PLAN AND THEREFORE, ERISA PREEMPTS ANY STATE LAW PURPORTING TO RESTRICT

THE FUND'S RIGHTS UNDER THIS PROVISION. FURTHERMORE, ANY STATE LAW DIRECTED AT INSURANCE COMPANIES WILL NOT APPLY TO THE FUND SINCE IT IS SELF-INSURED.

NO-FAULT INSURANCE COVERAGE

Where the Participant or eligible dependent is involved in a motor vehicle accident covered by a no-fault insurance policy whether or not required by state insurance law, the automobile no-fault insurance carrier will initially be liable for lost wages, medical, surgical, Hospital, and related charges and expenses up to the greater of:

- The maximum amount of basic reparation benefit required by applicable law; or
- The maximum amount of the applicable no-fault insurance coverage in effect.

The Plan will thereafter, consider any excess charges and expenses under the applicable provisions of the respective Plan in which you are provided health coverage. Before related claims will be paid through the Fund, the Participant or his eligible dependent will be required to sign a Reimbursement Agreement.

If the Participant or his/her eligible dependent fails to secure no-fault insurance as required by state law, the Participant or eligible dependent is considered as being self-insured and must pay the amount of the basic medical reparation expenses for himself and/or his eligible dependents arising out of the accident.

REFUND OF OVERPAYMENT OF BENEFITS - RIGHT OF RECOVERY

The Fund has the right to a refund if the Fund pays benefits for expenses incurred on account of you or your eligible dependent, and you or any other person or organization was paid in error, because:

- All or some of the expenses did not legally have to be paid by you or your eligible dependents.
- All or some of the payment made by the Fund exceeds the benefits under the Plan.
- All or some of the expenses were recovered from or paid by a source other than this Plan including another plan to which this Plan has secondary liability under the Coordination of Benefits provisions. This may include payments made as a result of claims against a third party for negligence, wrongful acts, or omissions.

The refund will equal the amount the Fund paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Fund paid.

If you or any person or organization that was paid does not promptly refund the full amount, the Fund may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Fund may have other rights in addition to the right to reduce future benefits.

22. COBRA CONTINUATION COVERAGE

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your eligible dependent spouse, and your eligible dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must make monthly self-payments to purchase COBRA continuation coverage.

If you are a Participant, you will become a "qualified beneficiary" if you lose your coverage under the Plan because the balance in your Administrative Account is exhausted resulting in the loss of eligibility.

If you are the spouse of a Participant, you will become a "qualified beneficiary" if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies.
- The member's balance in his/her Administrative Account is exhausted resulting in the loss of eligibility.
- You become divorced or legally separated from your spouse.

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

- The Participant (parent) dies.
- The Participant's (parent) Administrative Account balance is exhausted, resulting in the loss of eligibility.
- The Participant and spouse become divorced or legally separated.
- The child stops being eligible for coverage under the Plan as an eligible dependent upon attaining age 26.

Qualified Beneficiaries

A "qualified beneficiary" under COBRA is any Participant or eligible dependent who on the day before the qualifying event has coverage under the Plan, would otherwise lose such coverage due to the qualifying event and timely elects to receive COBRA coverage, as well as any eligible dependent child who is born to or placed for adoption with a Participant during the period of COBRA coverage.

If a qualified beneficiary with COBRA coverage acquires an eligible dependent, the eligible dependent may be added to coverage for the remainder of the COBRA coverage period. If a qualified beneficiary has a dependent who was eligible but not enrolled in the Plan at the time the qualified beneficiary enrolled for COBRA coverage because the dependent had other group health coverage at that time, and the dependent loses the other coverage due to exhaustion of

COBRA coverage, the qualified beneficiary may add the dependent to his or her coverage for the remainder of the COBRA coverage period within 30 days after the dependent's loss of the other coverage. You may also add a dependent as a qualified beneficiary due to birth or adoption of a child during the COBRA coverage period. Of course, adding a dependent to your coverage may cause an increase in your COBRA premiums.

WHEN IS COBRA COVERAGE AVAILABLE?

- The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has determined or been notified that a qualifying event has occurred.
- The Participant's Administrative Account balance is exhausted, resulting in the loss of eligibility.
- The Fund Office must be notified in the event of the Participant death.

YOU MUST GIVE NOTICE TO THE FUND OFFICE OF CERTAIN QUALIFYING EVENTS

You are responsible for providing the Fund Office with timely notice of the following qualifying events:

- **The divorce or legal separation of a Participant from his or her spouse**.
- A beneficiary ceasing to be covered under the Plan as an **eligible dependent child of a Participant (attains age 26).**
- The occurrence of a "second qualifying event" after a qualified beneficiary previously became entitled to COBRA with a maximum duration of 18 (or 29) months. This second qualifying event could include a Participant's death, entitlement to Medicare, divorce or legal separation or child losing eligible dependent status. (More information about second qualifying events is provided later in this section.)
- 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 that an individual is disabled during the first 60 days of COBRA coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18-month 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 are responsible for notifying the Plan of any of the previously listed five events. **Failure to provide the proper notice within the following required time frames may prevent you from obtaining or extending COBRA coverage**.

The Fund Office will determine whether a qualifying event has occurred. However, you should promptly notify the Fund Office of any of the qualifying events listed above. This will allow the Fund Office to process your continuation of coverage election efficiently and with little or no interruption in the handling of your claims.

PROCEDURES FOR NOTIFYING THE PLAN OF COBRA QUALIFYING EVENTS

To notify the Fund Office of these qualifying events, a "qualified beneficiary" can send a notice via U.S. First Class mail or fax to continue coverage **within the later of: 60 days from the date of the qualifying event or the date coverage was lost under the Plan due to the qualifying event**. The notice must be in a form that documents the date sent (*e.g.*, if sending by mail, the request must be postmarked no later than 60 days after the date described above). In the event of divorce or legal separation, you must also submit a copy of the divorce decree or written proof of

the legal separation. In the event of a Social Security Administration determination of disability, you must submit a copy of the Social Security disability determination.

If you are providing notice of a Social Security Administration determination of disability, the notice must be postmarked no later than 60 days after the latest of:

- The date of the disability determination by the Social Security Administration;
- The date on which the qualifying event occurs; or
- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event.

Notice of a Social Security disability determination must be submitted to the Fund Office *before* the end of the first 18 months of the COBRA continuation coverage.

If you are providing notice of a Social Security Administration determination that a qualified beneficiary is no longer disabled, the notice must be postmarked no later than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

Notice may be provided by the Participant or qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the Participant or qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event.

Address to Notify Plan Administrator of Qualifying Event

Heat and Frost Insulators Local No. 33 Health Fund
P.O. Box 5817
Wallingford, CT 06492-7617
Attn: COBRA Administrator

You may also fax your notification to the following number: (203) 284-8656.

HOW IS COBRA COVERAGE PROVIDED?

Once the Fund Office determines or receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

- When the qualifying event is the death of the Participant, the Participant and spouse's divorce or legal separation, or a dependent child's losing eligibility as an eligible dependent child (attains age 26), COBRA continuation coverage lasts for up to a total of 36 months for eligible dependents who are qualified beneficiaries. When the qualifying event is the result of the Participant's Administrative Account balance being exhausted, resulting in the loss of eligibility and the Participant became entitled to Medicare benefits less than 18 months before the loss of coverage caused by the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Participant lasts until 36 months after the date of Medicare entitlement.

For example, if a Participant becomes entitled to Medicare eight (8) months before the date on which his/her eligibility runs out, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Participant's hours of employment, COBRA

continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

1. **Disability extension of 18-month period of continuation coverage**

   If you or anyone in your family covered under this Plan is determined by the Social Security Administration to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month original period of continuation coverage.

2. **Second qualifying event extension of 18-month period of continuation coverage**

   If your family experiences another qualifying event (a "second qualifying event") while receiving 18 months of COBRA continuation coverage (or 29 months if disabled), the eligible dependents in your family who are qualified beneficiaries can get up to 18 additional months of COBRA continuation coverage (7 months if disabled) for a maximum of 36 months, if timely notice of the second qualifying event is properly given to the Fund Office. This extension may be available to any eligible dependents (if they are qualified beneficiaries) receiving continuation coverage if the Participant or former Participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as an eligible dependent child.

Qualifying Events and Maximum Periods of Continuation of Coverage

Coverage may continue on a self-pay basis as follows:

Qualifying Event	Participant	Spouse	Dependent Child(ren)
a) Participant eligibility is terminated because the balance in his/her Administrative Account is exhausted, resulting in the loss of eligibility.	18 months	18 months	18 months
b) Participant dies	N/A	36 months	36 months
c) Participant becomes divorced or legally separated	N/A	36 months	36 months
d) Dependent child ceases to have eligible dependent status	N/A	N/A	36 months
e) Disability as certified by Social Security Administration of any COBRA covered beneficiary	29 months	29 months	29 months

SELF-PAYMENT FOR COBRA COVERAGE

You and/or your eligible dependents that elect to continue coverage will be solely responsible for the payment of the monthly self-payment for the continued coverage. If an election is made after the qualifying event, the monthly self-payment for continuation coverage during the period preceding the election must be made within 45 days of the date of the election. Thereafter, the monthly self-payment may be paid in monthly installments within 30 days after the first of the month in which insurance coverage is provided.

OTHER THAN THE FIRST PAYMENT, UNDER NO CIRCUMSTANCES WILL THE OPTION TO MAKE SELF-PAYMENT TO THE FUND BE PERMITTED ON A RETROACTIVE BASIS. PAYMENTS MUST BE MADE CONTINUOUSLY AND WITHOUT INTERRUPTION. FAILURE TO MAKE THE MONTHLY SELF-PAYMENT WHEN DUE WILL RESULT IN THE IMMEDIATE TERMINATION OF YOUR COVERAGE WITHOUT ANY PROVISION FOR REINSTATEMENT.

The Fund assumes no responsibility or liability if you voluntarily allow your eligibility for benefits to terminate. If you have any reason to believe that your eligibility will be or has been terminated, you should contact the Fund Office as soon as possible to verify your eligibility status.

The Board of Trustees will set the monthly self-payment rates according to federal law, which allows the monthly self-payment to be set at a level not to exceed the full expected average group composite cost of such benefits, plus a 2% charge for administrative expenses. If the cost changes, as approved by the Board of Trustees, the Fund Office will revise the monthly self-payment rates (not more frequently than once in a 12-month period), you are required to pay. In addition, if the benefits change for active Participants, your coverage will change as well and the self-pay rates will also change.

More details of COBRA continuation coverage will be furnished to you and your eligible dependents when the Fund Office receives notice that one of the qualifying events has occurred. Therefore, we urge you and your eligible dependents to contact the Fund Office as soon as possible after one of those events.

After an election is made regarding COBRA coverage, no change will be allowed in the level of coverage for the duration of the continuation period.

You have the right to elect self-payment COBRA only for the coverage (plan of benefits) you were receiving or entitled to prior to the termination of eligibility.

TERMINATION OF COBRA COVERAGE

Coverage under COBRA will cease on the first of the following dates:

- The first of the month you have satisfied the eligibility provisions and have reestablished coverage in the Plan.
- The date the required monthly self-payment is due and unpaid (i.e., if payment not received within 30 days after the first of the month in which coverage is provided).
- The date, after COBRA coverage is elected, on which you and/or your eligible dependents first become covered under Medicare.
- The date, after COBRA coverage is elected, on which you and/or your eligible dependents first become covered under another group health plan.
- The date the applicable period of continuation coverage is exhausted (18, 29, or 36 months).
- The date the Plan terminates.
- The date the Employer that you worked for before the qualifying event stops contributing to the Plan and:
  - The Employer establishes one or more group health plans covering a significant number of the Employer's Employees formerly covered by this Plan; or
  - The Employer starts contributing to another multiemployer plan that is a group health plan.

Early Termination of COBRA Coverage

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

GENERAL INFORMATION

Continuation of coverage is optional for you and your eligible dependents. Each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA coverage. For example, both the Participant and the Participant's spouse may elect COBRA continuation coverage, either together as family coverage or independently as single coverage.

If you waive COBRA coverage during the 60-day election period, you may revoke the waiver and elect COBRA coverage at any time during the 60-day election period; however, COBRA coverage will be provided only from the date of revocation and not retroactive to the loss of coverage.

If you or your eligible dependents provide notice to the Fund Office of your divorce, a dependent ceasing to be covered under the Plan as an eligible dependent, or a second qualifying event, but you are not entitled to COBRA coverage, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA coverage.

Keep the Fund Office Informed of a Change to Your Address

In order to protect your family's rights, you should keep the Fund Office informed of the current addresses of all Covered Persons under the Plan who are or may become qualified beneficiaries. You should also keep copies for your records, of any notices you send to the Plan.

Plan Contact Information

Information about the Plan and COBRA coverage can be obtained upon request from:

Heat and Frost Insulators Local No. 33 Health Fund
P.O. Box 5817
Wallingford, CT 06492-7617
Attn: COBRA Administrator
1-800-446-8646

Unavailability of Coverage

If you provide notice to the Fund Office of a qualifying event, but are not entitled to COBRA, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within the same time frame that the Fund Office is required to provide an election notice.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

23. DEFINITIONS

These are some of the terms used in your booklet. Some other commonly-used terms are described within the booklet when they are used. PLEASE READ THESE TERMS CAREFULLY. They may help you understand your benefits better.

Allowable Expense means any necessary, reasonable, and customary item of expense, at least a part of which is provided by anyone of the plans that covers the person for whom a claim is made. When the benefits from a plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

Ambulatory Surgical Facility means any public or private establishment that:

- Is licensed as such by the state;
- Is supervised by a group of Physicians;
- Has permanent facilities;
- Is equipped and operated primarily for the purpose of performing Surgical Procedures; and
- Provides continuous Physician and registered graduate nursing services whenever a patient is in the facility.

An Ambulatory Surgical Facility does not include Physician's or Dentist's offices, or any facilities whose primary purpose is the termination of pregnancy, or a facility that provides services or other accommodations for patients to stay overnight.

Approved Clinical Trial means participation in either a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. (See pages 6-5 and 6-6 for coverage requirements.)

Complications of Pregnancy means:

- Conditions requiring Hospital stays when the pregnancy is not terminated and the diagnosis is distinct from pregnancy, but is adversely affected by pregnancy or caused by pregnancy; and
- Non-elective Cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Consultation means a review of the medical history of the patient, review of laboratory and x-ray examinations, an examination of the patient, and a report written by the consulting Physician if requested by the primary care Physician.

Covered Charges means the Reasonable and Customary charges that are incurred for the Medically Necessary treatment of conditions that are covered under this Plan.

Covered Employment means employment for which an Employer or Contractor is obligated to contribute to the Fund on behalf of an Employee in accordance with a collective bargaining agreement or participating agreement with Local No. 33.

Covered Person means any active Participant and such Participant's eligible dependent spouse and eligible dependent child(ren) who have completed all required formalities for enrollment for coverage under the Plan and are actually covered by the Plan.

Custodial Care means all supplies, including room and board, which are provided, whether you are disabled or not, primarily to assist in the activities of daily living. Such services and supplies are Custodial Care without regard to the practitioner or provider by whom or by which they are

prescribed, recommended, or performed. Some examples of such services are: help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

Dentist means a person authorized by law and duly licensed to practice dentistry.

Durable Medical Equipment means equipment prescribed by a Physician that is Medically Necessary and:

- Can withstand repeated use;
- Is primarily and customarily used for a medical purpose and is not generally useful in the absence of an Injury or Illness;
- Is not disposable or non-durable;
- It is appropriate for use in the home; and
- It is not primarily and customarily for your convenience.

The Fund will not pay for the rental and purchase of any such equipment that is not approved by the Fund, regardless of Medical Necessity. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric Hospital beds (with safety rails), electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Durable Medical Equipment does not include air conditioners, exercise equipment, saunas, air purifiers, arch support, articles of special clothing, bed pans, corrective shoes, dehumidifiers, elevators, wheel chair ramps, heating pads, hot water bottles, etc. This list is not exhaustive of items not considered Durable Medical Equipment.

Employee means anyone hired by an Employer or contractor who is covered by: (1) a collective bargaining agreement that requires his or her participation in the Fund; or (2) a participating agreement executed by his or her Employer requiring contributions to the Fund.

Employer means any Employer signatory to a collective bargaining agreement with Local No. 33 that obligates such Employer to make contributions to the Fund.

Experimental (or Experimental Procedure) means:

- Any medical procedure, equipment, treatment or course of treatment, or drug or medicine that is meant to investigate and is limited to research;
- Techniques that are restricted to use at centers which are capable of carrying out disciplined clinical efforts and scientific studies;
- Procedures which are not proven in an objective way to have therapeutic value or benefit;
- Any procedure or treatment whose effectiveness is medically questionable;
- Any procedure or is treatment that is found by the Fund or its designee not to be in Accordance with generally accepted medical and dental practice; and
- Any procedure or treatment that does not have governmental approval.

Genetic Information means the manifestation of a disease or disorder in an individual's family members.

Home Health Care Agency means an agency or organization that meets each of the following requirements:

- It is primarily engaged in and is federally certified as a Home Health Care Agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services;

- Its policies are established by a professional group associated with such agency or organization, including at least one Physician and at least one registered graduate Nurse, to govern the services provided;
- It provides for full-time supervision of such services by a Physician or by a registered graduate Nurse;
- It maintains a complete medical record on each patient; and
- It has an administrator.

Home Health Care Plan means a program for continued care and treatment of the Participant or eligible dependent established and approved in writing by such Participant's or eligible dependent's attending Physician within seven (7) days following termination of a Hospital confinement as a resident inpatient for the same or related condition for which the individual was Hospitalized, together with such Physician's certification that the proper treatment of the Injury or Illness would require continued confinement as a resident inpatient in a Hospital, in the absence of the services and supplies provided as part of the Home Health Care Plan.

Hospital means an institution that:

- Is primarily engaged in providing, by or under the supervision of Physicians, inpatient diagnostic and therapeutic services for the diagnosis, treatment, and rehabilitation of Injured, disabled, or sick persons;
- Maintains clinical records on all patients;
- Has bylaws in effect with respect to its staff of Physicians;
- Has a requirement that every patient be under the care of a Physician;
- Provides a 24-hour nursing service rendered or supervised by a registered graduate Nurse;
- Has in effect a Hospital utilization review plan;
- Is licensed pursuant to any state or agency of the state responsible for licensing Hospitals; and
- Has accreditation under one of the programs of the Joint Commission on Accreditation of Healthcare Organizations.

Unless specifically provided, the term "Hospital" does not include any institution, or part thereof, which is used principally as a rest facility, nursing facility, Convalescent Facility or facility for the aged or for the care and treatment of drug addicts or alcoholics, except as mandated by state law, nor does it mean any institution that makes a charge that you or your eligible dependents are not required to pay.

Illness means any sickness, disorder, or disease that is not employment-related. Pregnancy is treated in the same manner as an Illness under this Plan for you or an eligible dependent spouse.

Injury means physical damage to you or your eligible dependent's body caused by purely accidental means, independent of all other causes. Only Injuries that are not employment-related are considered for benefits under this Plan, except under the Life Insurance and Accidental Death and Dismemberment Benefits.

Local 33 means Allied Workers Local No. 33.

Medical Social Services means services rendered under the direction of a legally qualified Physician, by a qualified social worker holding a Master's degree from an accredited school of social work, including, but not limited to:

- Assessment of the social, psychological, and family problems related to or arising out of such Covered Person's Illness and treatment;

- Appropriate action and utilization of community resources to assist in resolving such problems; and
- Participation in the development of the overall plan of treatment for such Covered Person.

Medically Necessary (or Medical Necessity) means any service, supply, treatment, or Hospital confinement which:

- Is essential for the diagnosis or treatment of the Injury of Illness for which it is prescribed or performed;
- Meets generally accepted standards of medical practice; and
- Is ordered by a Physician.

The fact that a Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it Medically Necessary or make the expense a Covered Charge.

Medicare means the health insurance program set forth in Parts A and B, Title XVIII of the Social Security Act of 1965, as amended.

Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N." or "L.P.N."

Participant means an Employee who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.

Pharmacy means a licensed establishment where prescription drugs are dispensed by a pharmacist.

Physician means, with respect to any particular medical care and services, any holder of a certificate or license authorizing such holder or licensee to perform the particular medical or surgical services. This definition of Physician will include a licensed psychologist for the treatment of mental and/or nervous disorders and alcohol and substance use disorder treatment.

Reasonable and Customary means the usual charge made by a person, a group or an entity that renders or furnishes the services, treatments or supplies that are covered under this Plan. In no event does it mean a charge in excess of the general level of charges made by others who render or furnish such services, treatments, or supplies to persons: (a) who reside in the same area; and (b) whose Illness or Injury is comparable in nature and severity. The term "area" means a county or such greater area that is necessary to obtain a representative cross section of the usual charges made.

Skilled Nursing Services means one or more of the professional services that may be rendered by a registered graduate Nurse or by a licensed practical Nurse under the direction of a registered graduate Nurse.

Surgical Procedure means any procedure in the categories listed below:

- The incision, excision, or electrocauterization of any organ or part of the body;
- The manipulative reduction of a fracture or dislocation;
- The suturing of a wound; or
- The removal by endoscopic means of a stone or other foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder, or ureter.

Totally Disabled means that, because of Injury or Illness, a Participant is prevented from engaging in his customary occupation and performing any kind of work for pay or profit.

24. PLAN INFORMATION

Name of Plan

Heat and Frost Insulators Local No. 33 Health Fund

Plan Sponsor/Plan Administrator

The Plan is sponsored, administered and maintained by a joint Board of Trustees, consisting currently of six (6) Local No. 33 representatives and five (5) Employer representatives. Although this is an unequal number, the Local and Employer Trustees have equal voting rights. The Board of Trustees can be contacted as follows:

Board of Trustees
Mr. Rodney Snipes, Fund Administrator
Heat and Frost Insulators Local No. 33 Health Fund
P. O. Box 5817
Wallingford, CT 06492-7617

Phone: 1-800-446-8646
Fax: 1-203-284-8656

The Board of Trustees has delegated certain responsibilities for the Plan's day-to-day operations to the Administrator and staff at the Fund Office.

Contributing Employers

You may request confirmation from the Fund Office as to whether a particular contractor or Employer is a sponsor of or contributing Employer to this Plan, as well as the address of a contributing Employer.

You may obtain a complete list of the Employers and Employee organizations sponsoring the Plan upon written request to the Plan Administrator, and such information is available for examination at the Fund Office.

Reference to Collective Bargaining Agreement

The Fund is maintained pursuant to collective bargaining agreements or other agreements with Allied Workers Local No. 33 which provides for the rate of Employer contributions to the Fund and areas of work for which contributions are payable and certain other terms governing contributions. A copy of the collective bargaining agreement may be obtained upon written request to the Board of Trustees and is available for examination at the Fund Office.

The Type of Plan

The Heat and Frost Insulators Local No. 33 Health Fund is a health and welfare plan. The Plan provides Life Insurance and Accidental Death and Dismemberment Benefits on an insured basis. The Fund has purchased a policy of stop loss insurance to protect it against catastrophic claims. All other benefits described in this booklet are provided on a self-insured basis to eligible Participants and their eligible dependents.

The Life Insurance, Accidental Death and Dismemberment Insurance is currently insured through Prudential Life Insurance Company and the specific stop loss insurance is issued by HCC Life Insurance Company. The policies and rate are continually reviewed and the insurance carriers and coverage's are subject to change.

<u>Prudential Life Insurance Company</u>
Group Life Claim Division
P. O. Box 8517
Philadelphia, PA 19176

<u>Stop-Loss Insurance</u>
HCC
401 Edgewater Place, Suite 400
Wakefield, MA 01880
Phone: 1-800-676 1771
Fax: 1-781-245 1042

Names and Addresses of the Members of the Board of Trustees

Labor Trustees	**Management Trustees**
Mr. Kevin Cwikla 419 Levita Road Lebanon, CT 06249	Mr. Paul M. Camara, Jr. Axion Specialty Contracting 65 Boston Post Road West Marlborough, MA 01752
Mr. Peter Gallo 35 Chapin Avenue Rocky Hill, CT 06067	Mr. Gary S. Devoe 3 Morse Road, Unit 2D Oxford, CT 06478
Mr. Peter Karas 42 Rockdale Avenue Oakville, CT 06779	Mr. Brian J. Flynn President, B.C. Flynn Contracting Corp. 200 Brenner Drive Congers, NY 10920
Mr. Stephen Morrell 10 Cynthia Circle West Haven, CT 06516	Mr. Thomas Langan Langan Insulation P.O. Box 749 North Haven, CT 06473
Mr. William Raffile 4½ Mellor Road Wallingford, CT 06492	Mr. Joseph P. Leo, Jr. CIEA President, Atlantic Contracting & Specialties 925 Saw Mill River Road Yonkers, NY 10710
Mr. Donald Scoopo 21 Green Glenn Terrace| East Haven, CT 06512	

The right is reserved in the Plan for the Board of Trustees, as Administrator, to terminate, suspend, withdraw, amend, or modify the Plan in whole or in part at any time.

Employer Identification Number (assigned **by the Internal Revenue Service)**

06-1078051

Plan Number

In conjunction with the Employer Identification Number, Plan number 501 is used to denote the Trust in Government filings.

Agent for Service of Legal Process

If for any reason you wish to seek legal action, you may serve legal process upon:

Heat and Frost Insulators Local No. 33 Health Fund
618 South Colony Road
Wallingford, CT 06492

In addition, legal process may be served upon any Board of Trustee member.

Plan Year

The records of the Plan are kept on the basis of a fiscal year, which begins on January 1st and ends on the following December 31st.

The Source of Contributions to the Fund

The Plan's benefits are financed through Employer contributions made in accordance with various collective bargaining agreements, investment earnings, COBRA self-payments and Employee self-payments.

The Plan Administrator will provide you, upon written request, with information as to whether a particular Employer is contributing to this Plan on behalf of Participants working under collective bargaining agreements and if so, with that Employer's address.

The Identity of Any Organization Used for the Accumulation of Assets Through Which Benefits Are Provided

Benefits are provided from the Fund's assets, which are accumulated under the provisions of the collective bargaining agreements and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to Covered Persons and defraying reasonable administrative expenses. The Fund's assets and reserves are held in custody by Wells Fargo Bank and the Fund's investment managers are Western Asset Core Plus Bonds, Vanguard Total Stock Market Index, and Vanguard Total International Stock Index. Fiduciary Investment Advisors acts as the Board of Trustees investment advisor.

Eligibility

The Fund's requirements with respect to eligibility, as well as circumstances that may result in disqualification, ineligibility, or denial or loss of benefits, are described in Section 1.

Appeal Procedure

If a Covered Person is denied, in whole or in part, any benefits under this Plan, as specified in Section 503 of the Employee Retirement Income Security Act, remedies are available and set forth in the section of this booklet entitled, "*Denial of Claims and Procedures for Appeal*" in Section 20.

Selection of Physicians and Facilities

The Plan extends the Anthem Blue Cross Blue Shield of Connecticut's Century Preferred provider network for Hospital and medical services along with adjudicating claim payments. The Plan does not provide Hospital or medical services. Accordingly, the Plan is not responsible for any acts or omissions by Hospitals or other facilities, or by Physicians, other medical professionals, or any facility staff member or Employee thereof.

No Liability for the Practice of Medicine or Dentistry

The Plan, Trustees or any of their designees are **not** engaged in 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 to be delivered to you by any Physician, Dentist or other provider. Neither the Plan, Trustees, nor any of their designees, will have liability whatsoever for any loss or Injury caused to you by any Physician, Dentist or provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Qualified Medical Child Support Orders

Upon written request to the Fund Office, you may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations. Refer to Section 2 for information on QMCSOs.

Procedure for Obtaining Additional Plan Documents

If you wish to inspect or receive copies of additional documents relating to the Plan, you may contact the Fund Office. You may be charged a reasonable fee to cover the copying cost of any materials you wish to receive. Certain documents pertaining to the Fund, such as minutes of meetings, may be inspected at the Fund Office but copies are not permitted.

Statement of Federal Law Relating to Maternity and Newborn Infant Coverage

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Federal Law Relating to Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All states or reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan and described previously.

If you would like more information on WHCRA benefits, contact the Fund Office.

Plan Amendment or Termination

The Board of Trustees reserves the right to change or discontinue the types and amounts of benefits under the Plan and the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Plan benefits and eligibility rules for active or disabled Participants and their eligible dependents:

- Are not guaranteed;
- May be changed or discontinued by the Board of Trustees;
- Are subject to the Trust Agreement, which establishes and governs the Fund's operations;
- Are subject to the provisions of the group insurance policies purchased by the Board of Trustees; and
- Are subject to changing legislation.

Amendments made to the Plan will be communicated to all Plan Participants, in writing.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

In the event of a Plan termination, only claims and expenses incurred prior to the termination date will be paid in accordance with the Plan. Payment will be made from the assets remaining in the Fund, including any insurance policies issued to the Fund, for the purpose of providing benefits. If there are not enough assets remaining to pay all outstanding claims, the Trustees will decide the manner in which the remaining assets will be used.

Discretionary Authority of the Plan Administrator and Its Designees

The Board of Trustees, acting as a body, and only the Board of Trustees, in its sole discretion, has the right to amend or terminate the Plan of Benefits and the Trust Agreement. Any discretionary action taken by the Board of Trustees in determining any matter, including your rights or benefits under the Plan will be decided in a nondiscriminatory manner, as required by law. Any decisions made by the Board of Trustees should receive judicial deference to the extent that they do not constitute an abuse of discretion.

In carrying out their respective responsibilities under the Plan, the Trustees, their designees and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, will have discretionary and sole authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan and decide any fact related to eligibility for and entitlement to Plan benefits. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

No Local Union officer, business agent, Local Union Employee, Employer or Employer representative, association or association representative, individual trustee, Fund Office personnel, consultant, attorney or any other person is authorized to speak for, or on behalf of this Fund, or to commit or to legally bind the Board of Trustees of this Fund in any matter whatsoever relating to the Fund, unless such person will have been given express written authority from the Board of Trustees to act in such matter. All Participants are warned not to rely upon any opinion or interpretation expressed by any such individual. All inquiries, requests for rulings, interpretations, and decisions **must** be directed to the full Board of Trustees in care of the Fund Office.

No Guarantee

No benefits or rules described in this Summary Plan Description are guaranteed (vested) for any Participant, spouse, or dependent. All benefits and rules may be changed, reduced, or eliminated prospectively at any time by the Board of Trustees, at their discretion. All changes adopted by the Board of Trustees to the Plan of Benefits or the rules will be published in writing and circulated to the Participants, as required by law, so that the Participants may have up-to-date information concerning their rights, benefits, and privileges.

25. PRIVACY REQUIREMENTS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) AND THE GENETIC INFORMATION AND NON-DISCRIMINATION ACT OF 2008 (GINA)

The Plan maintains a "Privacy Notice" describing how your medical information may be used or disclosed, as well as how you may gain access to your medical information and your other rights regarding that information. The Plan's Privacy Notice is reproduced here for your careful review:

Background: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan Participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by the Heat and Frost Insulators Local No. 33 Health Fund (the "Fund"), as sponsored by the Board of Trustees (the "Plan Sponsor").

The Fund needs to create, receive, and maintain records that contain health information about you to administer the Fund and to provide you with health care benefits. This notice describes the Fund's health information privacy policy with respect to your Medical, Prescription Drug, Dental, Vision, and Hearing Benefits. The notice tells you the ways the Fund may use and disclose health information about you, describes your rights, and the obligations the Fund has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care providers.

Heat And Frost Insulators Local No. 33 Health Fund
Privacy Notice

Section 1: Purpose of This Notice and Effective Date

This Notice Describes:

1. How medical information about you may be used and disclosed; and
2. How you may obtain access to this information.

Please review this information carefully.

Effective date. The effective date of this Notice is September 23, 2013.

This Notice is required by law. The Heat and Frost Insulators Local No. 33 Health Fund (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI),
2. Your rights to privacy with respect to your PHI,
3. The Plan's duties with respect to your PHI,
4. Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services, and
5. The person or office you should contact for further information about the Plan's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all information related to your past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

PHI refers to your health information held by the Plan.

When the Plan May Disclose Your PHI

The Plan Sponsor has amended its Plan documents to protect your PHI as required by federal law. Under the law, the Plan may disclose your PHI without your consent or authorization in the following cases:

- ***At your request.*** If you request it, the Plan is required to give you access to certain PHI in order to allow you to inspect it and/or copy it.
- ***As required by the Department of Health and Human Services (HHS) .*** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.

- ***For treatment, payment or health care operations.*** The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object in order to carry out:
  - Treatment,
  - Payment, or
  - Health care operations.

The Plan does not need your consent or authorization to release your PHI when:
- you request it,
- a government agency requires it, or
- the Plan uses it for treatment, payment or health care operations.

Definitions of Treatment, Payment or Health Care Operations	
Treatment is health care.	Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. ***For example:*** The Plan discloses to a treating orthodontist the name of your treating Dentist so that the orthodontist may ask for your dental X-rays from the treating Dentist.
Payment is paying claims for health care and related activities.	Payment includes but is not limited to making coverage determinations and payment. These actions include billing, claims management, subrogation, Plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review and preauthorization. ***For example:*** The Plan tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.
HealthCare Operations keep the Plan operating soundly.	Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. ***For example:*** The Plan uses information about your medical claims to refer you to a disease management program, to project future benefit costs or to audit the accuracy of its claims processing functions.

When the Disclosure of Your PHI Requires Your Written Authorization

The Plan must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

The Plan may provide health information for the purpose of evaluating and processing a claim for Accident and Sickness benefits; however, the Plan will obtain your written authorization before it will use or disclose any health information for this purpose.

Disclosure to other benefit plans. On certain occasions, the Plan may need to provide health information for the purpose of evaluating and processing a claim for Accident and Sickness or Social Security Disability benefits; however, the Plan will obtain your written authorization before it will use or disclose any health information for this purpose.

For marketing purposes. The Plan will request your authorization for any use or disclosure of PHI for marketing, except in situations involving a face-to-face communication or a promotional gift of nominal value. The Plan is not in the business of marketing PHI, and it does not expect to do so in the future.

Sale of PHI. The Plan will request your authorization for any disclosure of PHI, which constitutes a sale of PHI. Please note, however, that the Plan is not in the business of selling PHI and it does not expect to do so in the future.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI For Which Consent, Authorization or Opportunity to Object Is Not Required

In general, the Plan does not need your consent to release your PHI if required by law or for public health and safety purposes.

The Plan is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

1. ***When required by law.***
2. ***Public health purposes.*** When permitted for purposes of public health activities. This includes reporting product defects, permitting product recalls and conducting post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

3. ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
4. ***Oversight activities.*** To a public health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
5. ***Court proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request, provided certain conditions are met, including that:
    a. the requesting party must give the Plan satisfactory assurances a good faith attempt has been made to provide you with written notice, and
    b. the notice provided sufficient information about the proceeding to permit you to raise an objection, and
    c. no objections were raised or were resolved in favor of disclosure by the court or tribunal.
6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).
7. ***Law enforcement emergency purposes.*** For law enforcement purposes if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Plan in its best judgment determines that disclosure is in the best interest of the individual. Law enforcement purposes include:
    a. identifying or locating a suspect, fugitive, material witness or missing person, and
    b. disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.
8. ***Determining cause of death.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties.
9. ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.
10. ***Research.*** For research, subject to certain conditions.
11. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. ***Workers' compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
13. ***Specialized Government Functions.*** When required, to military authorities under certain circumstances, to authorized federal officials for lawful intelligence, counter intelligence and other national security activities.

Except as otherwise indicated in this notice, uses and disclosures of your PHI will be made only with your written authorization subject to your right to revoke your authorization.

Other Uses or Disclosures

The Plan may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Plan may disclose protected health information to the sponsor of the Plan for reviewing your appeal of a benefit claims or for other reasons regarding the administration of this Plan. The "plan sponsor" of this Plan is the Board of Trustees.

Section 3: Your Individual Privacy Rights

The following is a description of your individual privacy rights. It is important to note that requests to invoke your rights regarding your medical benefits should be directed to Blue Cross Blue Shield of Rhode Island. All other requests (for dental, vision and hearing) should be directed to the Plan. The Plan contracts with several vendors, also called "business associates," who provide services to the Plan and services and benefits to you on the Plan's behalf. Once the Plan is notified that you choose to invoke any of the individual rights listed below, it will notify the appropriate vendor on your behalf. Because some of your PHI is maintained and used by these business associates to provide or process your benefits, the Plan requires that they administer certain aspects of the individual privacy rights.

You may contact the Privacy Official at the address and phone number listed below:

Privacy Official
Heat and Frost Insulators Local No. 33 Health Fund
P.O. Box 5817
Wallingford, CT 06492-7617
Phone: 1-800-446-8646

You May Request Restrictions on PHI Uses and Disclosures

You may request the Plan to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request if the Plan Administrator or Privacy Official determines it to be unreasonable.

Protected Health Information (PHI): includes all individually identifiable health information transmitted or maintained by the Plan, regardless of the form of the PHI.

In addition, the Plan will accommodate an individual's reasonable request to receive communications of PHI **by alternative means or at alternative locations** where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Privacy Official listed at the address and phone number listed above.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

You may request your hardcopy of electronic information in a format that is convenient for you and the Plan will honor that request to the extent possible. You may also request a summary of your PHI.

The Plan must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline and if the Plan provides you with a notice of the reason for the delay and the expected date by which the requested information will be provided.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Plan's Privacy Official (at the address listed above).

Designated Record Set: includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

In limited circumstances, access may be denied. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to Plan and the Secretary of the U.S. Department of Health and Human Services.

You Have the Right to Amend Your PHI

You have the right to request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Plan's Right to Amend Policy for a list of exceptions.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

If you disagree with the record of your PHI, you may amend it.

If the Plan denies your request to amend your PHI, you still have the right to have your written statement disagreeing with that denial included in your PHI.

Forms are available for these purposes.

You should make your request to amend PHI to the Plan's Privacy Official (at the address listed above).

You or your personal representative will be required to complete a form to request amendment of the PHI.

The covered entity may require individuals to make requests for amendment in writing and to provide a reason to support the requested amendment. The Plan must inform individuals in advance of such requirements.

You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years before the date of your request. We do not have to provide you with an accounting of disclosures related to treatment, payment, health care operations, or disclosures made to you or authorized by you in writing. See the Plan's Accounting for Disclosure Policy for the contents of an accounting.

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

You have the right to request and receive a paper copy of this Notice at any time, even if you have received the Notice previously or agreed to receive the Notice electronically. To obtain a paper copy of this Notice, contact the Plan's Privacy Official (at the address listed above).

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

You may designate a personal representative by completing a form that is available from the Fund Office.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Plan will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Plan will automatically consider a spouse to be the personal representative of an individual covered by the Plan. In addition, the Plan will consider a parent, guardian, or other person acting *in loco parentis* as the personal representative of an unemancipated minor unless applicable law requires otherwise. A spouse or a parent may act on an individual's behalf, including requesting access to their PHI. Spouses and unemancipated minors may, however, request that the Plan restrict information that goes to family members as described above at the beginning of Section 3 of this Notice.

You should also review the Plan's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Plan will automatically consider an individual to be a personal representative.

You May Request Confidential Communications

The Plan will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Plan's Privacy Official (at the address listed previously).

Section 4: The Plan's Duties

Maintaining Your Privacy

This notice is written to inform you of the Plan's obligation to maintain the privacy of your PHI.

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

In addition, the Plan is now required to notify you of anything the law defines as a breach of your unsecured PHI, and you have a right to, and will receive, appropriate notifications in the event of any such breach.

The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to you and to all past and present Participants and beneficiaries for whom the Plan still maintains PHI.

The Privacy Notice will be provided via first class mail to all named Participants. Any other person, including dependents of named Participants, may receive a copy upon request.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

The Plan must limit its uses and disclosures of PHI or requests for PHI to the ***minimum necessary*** amount to accomplish its purposes.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,

- Disclosures made to the Secretary of the U.S. Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

The Plan Will Not Use or Disclose Genetic Information PHI for Underwriting

In accordance with the Genetic Information Nondiscrimination Act ("GINA"), the Plan will not use PHI that is genetic information for underwriting purposes. "Underwriting purposes" are broadly defined to include rules for eligibility, enrollment, cost sharing, computation of premium or computation amounts and incentives for participating in wellness programs, as well as activities related to the creation, renewal, or replacement of health insurance or health benefits.

Section 5: Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Plan's Privacy Official (at the address listed above).

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), at the following website:

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Alternatively, you can call OCR at 800-368-1019. The Plan will not retaliate against you for filing a complaint.

> You have the right to file a complaint if you feel your privacy rights have been violated.
>
> The Plan may not retaliate against you for filing a complaint.

Section 6: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at the Fund Office (address and telephone number listed previously).

Section 7: Conclusion

PHI use and disclosure by the Plan is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

Limitations on the Use and Disclosure of Genetic Information Policy Under GINA

This policy is adopted in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by Health Information Technology for Economic and Clinical Health (HITECH) Act and the Genetic Information Non-Discrimination Act of 2008 (GINA). If the privacy rules are changed by the Department of Health and Human Services, the Plan will follow the revised rules:

The Plan will not use or disclose PHI that is genetic information for underwriting purposes.

Genetic information includes, with respect to an individual, information about:

- The individual's genetic tests;
- The genetic tests of the individual's family members;
- The manifestation of a disease or disorder in family members (described below) of such individual; or
- Any request for, or receipt of, genetic services, or participation in clinical research, which includes genetic services, by the individual or any family member (described below) of the individual.

References to "family members" include: parents, spouses, siblings, children, grandparents, grandchildren, aunts, uncles, nephews, nieces, great-grandparents, great-grandchildren, great aunts, great uncles, first cousins, great-great grandparents, great-great grandchildren and children of first cousins, whether by consanguinity (such as siblings who share both parents) or affinity (such as by marriage or adoption). In addition, references to genetic information of an individual or family member includes the genetic information of a fetus carried by the individual or family member, and any embryo legally held by an individual or family member using assisted reproductive technology.

Underwriting purposes is defined broadly to include:

- Rules for, or determination of, eligibility (including enrollment and continued eligibility) for, or determination of coverage for, benefits under the Plan. Among other items, this includes changes in deductibles or other cost sharing mechanisms in return for activities such as completing a health risk form or being in a wellness program;
- The computation of premium or contribution amounts under the Plan. Among other items, this includes discounts, rebates, payment in kind or any other premium differential mechanisms in return for completing a health risk assessment or participating in a wellness program;
- The application of any pre-existing condition exclusion under the Plan; and
- Other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits.

Underwriting purposes do not include determinations of medical appropriateness where an individual seeks a benefit under the Plan.

26. STATEMENT OF RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

You have the right to:

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

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, your spouse, or your eligible dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You, your spouse, or your eligible dependents may have to pay for such coverage. Review this SPD and any documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you

may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

However, in all cases including those described in the above paragraph, you must first exhaust your administrative remedies under the Plan by following the *Denial of Claims and Procedures for Appeal* described in Section 20 before you may file suit in any court.

Assistance With Your Questions

If you have any questions about your Plan (for example, any questions about the processing of your claims, or allowances considered by Plan, covered expenses, or questions regarding your eligibility), you should contact the Fund Office below:

Heat and Frost Insulators Local No. 33 Health Fund
P.O. Box 5817
Wallingford, CT 06492-7617
Phone: 1-800-446-8646

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

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

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

- Calling 1-866-444-3272;
- Sending electronic inquires to www.askebsa.dol.gov; or
- Visiting the website of the EBSA at www.dol.gov/ebsa.

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