

INTERNATIONAL UNION OF PAINTERS AND ALLIED TRADES

DISTRICT COUNCIL NO. 21

WELFARE FUND

SUMMARY PLAN DESCRIPTION

**For All Covered Active Participants, Retirees,
and Eligible Dependents
(Except Active Participants, Retirees, and Eligible
Dependents covered under PLAN H)**

January 1, 2023

**International Union of Painters and Allied Trades
District Council No. 21 Welfare Fund**

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The Board of Trustees is pleased to provide you with this updated booklet describing the benefits available to you and your eligible dependents under the International Union of Painters and Allied Trades District Council No. 21 Welfare Fund (referred to in this booklet as the "Fund" or the "Plan"). This Plan believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act, which shall be explained in more detail in the section “Your Benefits at a Glance” found below in Section 1 of this document.

The benefits for Active Participants and their eligible dependents may include:

- **hospital and medical coverage** through one of the following providers: Keystone Health Plan East and QCC Insurance Company’s (“QCC”) Keystone Point of Service Program (“POS”) - QCC is a subsidiary of Independence Blue Cross; QCC’s Personal Choice Health Benefits Program; or through the Independence Blue Cross (“IBX”)
- **prescription drug benefits** through BeneCard PBF Member Services (“BeneCard”)
- **dental benefits** through Fidelio Dental Insurance Company (“Fidelio”)
- **vision services** through National Vision Administrators (“NVA”)
- **life insurance coverage (for eligible Active Participants only)** through Amalgamated Insurance Company which pays a benefit to your beneficiary if you die from any cause while covered by the Plan
- **accidental death and dismemberment benefits (for eligible Active Participants only)** through Amalgamated Insurance Company which pay a lump sum to your beneficiary if you die from an accident and a benefit to you in the event of loss of one or more limbs, or your eyesight, due to an accident
- **weekly disability benefits (for eligible Active Participants only)** which pay a weekly benefit if you become temporarily disabled as the result of a non-work related injury or illness

The benefits for Retirees and their eligible dependents may include:

- **hospital and medical coverage for retirees under age 65** through one of the following providers: Keystone Health Plan East POS or QCC’s Personal Choice Benefits Program;
- **hospital and medical coverage for retirees over age 65** through United American Insurance Company (“United”)
- **prescription drug benefits** through Benecard Services, LLC (“Benecard”)*
 - *Medicare-eligible over-65 retirees receive their drug benefits through Medicare Part D
- **dental benefits** through Fidelio Dental Insurance Company (“Fidelio”)
- **vision services** through National Vision Administrators (“NVA”)

This booklet provides a description, written in everyday language, of plan provisions in effect as of January 1, 2023, and taken together with the description of benefits described herein along with the description of benefits you receive from the Plan’s providers, this booklet constitutes a summary plan description, or “SPD.” Please keep all of the summaries together in a convenient place, where you will have them for future reference and can share them with your family.

Although these booklets provide essential information about your benefits, this information is



intended only as a summary of the terms under which benefits are provided. Additional information concerning your benefits may also be contained in related documents such as insurance contracts. The SPD, together with the insurance contracts are the plan documents pursuant to which benefits are provided. If there is ever a conflict between the summary plan description and the insurance contracts, the applicable insurance contracts will govern.

If you have any questions about the Plan, please contact the Fund Office. For questions on a particular benefit, contact the provider of that benefit. There is contact information for all providers which can be found within this SPD in the Section(s) addressing each respective benefit provided by the Fund.

Sincerely,

The Board of Trustees



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YOUR BENEFITS AT A GLANCE - PLANS A, B, E, F, G, N, HA, RES AND AP

There are two levels of benefits under the Fund –

A higher level (called Plan A, Plan E, Plan F, or Plan RES) and a lower level (called Plan B, Plan G, Plan N, Plan HA or Plan AP).

A summary of higher level of benefits appears below followed by a summary of the lower level.

YOUR BENEFITS AT A GLANCE FOR PLANS A, E, F, AND RES For Active Participants and their Eligible Dependents

Hospital and Medical Benefits

Provided by IBX-Personal Choice

See your Personal Choice summary for more details. Generally, though:

- When you receive “**in-network**” services, there is no deductible, coinsurance, or lifetime maximum. There is a \$10 copay for primary care office visits and a \$20 copay for specialist office visits. The copay for an emergency room visit is \$40, which is waived if you are admitted to the hospital. For hospital admissions, there is a special copay of \$75 per day, up to a maximum of \$375 per admission (for up to 5 days). There is a \$28 copay for outpatient urgent care
- When you receive “**out-of-network**” services, you have an annual deductible of \$300 per person and \$600 per family, thereafter you pay 30% of the Plan Allowance plus the difference between the provider’s charge and the Plan Allowance.

Prescription Drug Benefits

Provided through Benecard:

- If you go “in-network” to a **participating pharmacy**, you have a \$15 copay for a generic drug and a \$25 copay for a brand name drug and you will receive up to a 30-day supply. Through the **participating pharmacy**, you will have a \$30 copay for a generic drug and a \$50 copay for a brand name drug and will receive up to a 90-day supply.
- If you go through the **mail order** service, you will have a \$30 copay for a generic drug and a \$50 copay for a brand name drug and will receive up to a 90-day supply.

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

Dental Benefits

Provided through Fidelio A Plan (“A Plan”):

- You have a choice of in-network or out-of-network dentists.
- The Plan has established a maximum allowable charge for each covered service.
- When you receive services **in-network**, the Plan pays a specified percentage of the allowable charge (for example, 90%) and your copay is the remaining percentage (for example, 10%).
- When you go **out-of-network**, the Plan pays the same amount (a specified percentage of the allowable charge) it would pay if you went in-network. You will be responsible for paying 100% of any amount the dentist charges above what the Plan pays.

The Plan provides an annual maximum for the plan year of \$1,500 per covered person for all covered dental services (except orthodontia, dental implants or Invisalign where separate benefit rules apply – see summary of benefits for A Plan).

The Plan will provide eligible participants and dependents age 19 or older an **in-network** orthodontic benefit of \$1,000 per lifetime OR an **out-of-network** orthodontic benefit of 50% of the dentist’s charges, up to a lifetime limit of \$500.

The Plan also provides an **in-network** orthodontic benefit of \$4,000 per lifetime OR an **out-of-network** benefit of 50% of the dentist’s charges up to \$2,000 per lifetime for eligible dependent children up to age 19.

Predetermination from Fidelio is required for certain orthodontic procedures above \$300.00 – see summary of benefits.



Vision Benefit

Provided through National Vision Administrators (“NVA”):

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

- Age 18 and under, one exam and lenses or contacts every 12 months, frames every 24 months,
- Age 19 and older, one exam and glasses (lenses and frames) or contact lenses every 24 months.

Weekly Disability Benefits (for Active Participants only)

Provided through the Fund Office:

If you become disabled while covered by the Fund, you may be eligible for a weekly disability benefit from the Fund of \$350 per week for up to 26 weeks for any one disability. Weekly disability benefits are not paid for job-related injuries or illness. *This benefit is not available under Plan RES.*

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

Provided through Amalgamated Insurance Company (“Amalgamated”) and the Fund Office:

- \$50,000 is paid to your beneficiary if you die from any cause while covered by the Fund.
- If you die as the result of an accident, an additional \$50,000 is paid to your beneficiary.
- Up to \$30,000 may be paid to you if you lose one or more limbs, or your eyesight, as the result of an accident.

This benefit is not available under Plan RES.

YOUR BENEFITS AT A GLANCE FOR PLANS B, G, N, HA & AP

And for active participants who work fewer hours than needed for Plan A and F benefits and their eligible dependents

Hospital and Medical Benefits

See your IBX-Personal Choice summary for more details. Generally, though:

- When you receive “in-network” services, there’s no annual deductible, coinsurance, or lifetime maximum, a \$15 copay for primary care office visits and a \$25 copay for specialist office visits. The copay for an emergency room visit is \$40, which is waived if you’re admitted to the hospital. For hospital admissions, there is a special copay of \$100 per day, up to a maximum of \$500 per admission (for up to 5 days). There is a \$28.00 copay for outpatient urgent care
- When you receive “out-of-network” services, you have an annual deductible of \$500 per person and \$1,000 per family, and 30% coinsurance. The Plan pays the remaining 70%.

Prescription Drug Benefits

Same as Plans A, E, F, and RES.

Dental Benefits

Provided through Fidelio B Plan (“B Plan”):

- You have a choice of in-network or out-of-network dentists.
- The Plan has established a maximum allowable charge for each covered service.
- When you receive services **in-network**, the Plan pays a specified percentage of the allowable charge (for example, 70%) and your copay is the remaining percentage (for example, 30%).
- When you go **out-of-network**, the Plan pays the same amount (a specified percentage of the allowable charge) it would pay if you went in-network. You will be responsible for paying 100% of any amount the dentist charges above what the Plan pays.

The Plan provides an annual maximum for the plan year of \$1,500 per covered person for all covered dental services (except orthodontia, dental implants or Invisalign where separate benefit rules apply – see summary of benefits for B Plan). The Plan will provide eligible participants and dependents age 19 or older an **in-network** orthodontic benefit of \$1,000 per lifetime OR an **out-of-network** orthodontic benefit of 50% of the dentist’s charges, up to a lifetime limit of \$500.

The Plan also provides an **in-network** orthodontic benefit of \$4,000 per lifetime OR an **out-of-network** benefit of 50% of the dentist’s charges up to \$2,000 per lifetime for eligible dependent children up to age 19. Predetermination from Fidelio is required for certain orthodontic procedures above \$300.00 - see summary of benefits.

Vision Benefits

Same as Plans A, E, F, and RES.

YOUR BENEFITS AT A GLANCE

For retirees under Age of 65 and their Eligible Dependents not eligible for Medicare - Plans A, B, E, F, G, N, HA and AP



YOUR BENEFITS AT A GLANCE – PLAN L

A summary of your benefits appears below.

YOUR BENEFITS AT A GLANCE FOR ACTIVE PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS

Hospital and Medical Benefits

Provided by Keystone Health Plan East and QCC Insurance Company—Keystone POS C3F402

See your Keystone POS Program for more details. Generally, though:

- When you receive “**referred**” services, there is no deductible, coinsurance, or lifetime maximum. There is a \$20 copay for primary care office visits and a \$40 copay for specialist office visits, unless otherwise noted. The copay for an emergency room visit is \$100 per visit. For hospital admissions, there is a special copay of \$250 per day (up to 5 days), up to a maximum of \$1,000 per admission.
- When you receive “**self-referred**” services, you have an annual deductible of \$1,500 per person and \$4,500 per family, thereafter you pay 50% of the Plan Allowance plus the difference between the provider’s charge and the Plan Allowance. The co-pay for an emergency room visit is \$100, no deductible. For hospital admissions, after your deductible is reached, you must pay 50% (up to maximum of 70 days). The out-of-network benefits are subject to a lifetime maximum of \$500,000.

Prescription Drug Benefits

Provided through Benecard:

- If you go “in-network” to a **participating pharmacy**, you have a \$15 copay for a generic drug and a \$25 copay for a brand name drug and you will receive up to a 30-day supply. Through the **participating pharmacy**, you will have a \$30 copay for a generic drug and a \$50 copay for a brand name drug and will receive up to a 90-day supply.
- If you go through the **mail order** service, you have a \$30 copay for a generic drug and a \$50 copay for a brand name drug and will receive up to a 90-day supply.

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

Dental Benefits

Provided through Fidelio B Plan (“B Plan”):

- You have a choice of in-network or out-of-network dentists.
- The Plan has established a maximum allowable charge for each covered service.
- When you receive services in-network, the Plan pays a specified percentage of the allowable charge (for example, 70%) and your copay is the remaining percentage (for example, 30%).
- When you go out-of-network, the Plan pays the same amount (a specified percentage of the allowable charge) it would pay if you went in-network. You will be responsible for paying 100% of any amount the dentist charges above what the Plan pays.

The Plan provides an annual maximum for the plan year of \$1,500 per covered person for all covered dental services (except orthodontia, dental implants or Invisalign where separate benefit rules apply – see summary of benefits for B Plan).

The Plan will provide eligible participants and dependents age 19 or older an **in-network** orthodontic benefit of \$1,000 per lifetime OR an **out-of-network** orthodontic benefit of 50% of the dentist’s charges, up to a lifetime limit of \$500.

The Plan also provides an **in-network** orthodontic benefit of \$4,000 per lifetime OR an **out-of-network** benefit of 50% of the dentist’s charges up to \$2,000 per lifetime for eligible dependent children up to age 19.

Predetermination from Fidelio is required for certain orthodontic procedures above \$300.00 – see summary of benefits.

Provided through National Vision Administrators (“NVA”):

You may choose an NVA participating provider or another provider of your choosing; however, your coverage may differ depending on whether the provider is in the NVA network. The Plan provides vision benefits as follows:

- Age 18 and under, one exam and lenses or contacts every 12 months, frames every 24 months.
- Age 19 and older, one exam and glasses (lenses and frames) or contact lenses every 24 months.



If you retire before the age of 65 and are in good standing with the Union, you will receive coverage under the “B” Plan. If you’re eligible for Medicare, the Fund offers Medicare Supplement coverage.



Weekly Disability Benefits (for Active Participants only)

Provided through the Fund Office:

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

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

Provided through Amalgamated Insurance Company (“Amalgamated”) and the Fund Office:

- \$50,000 is paid to your beneficiary if you die from any cause while covered by the Fund.
- If you die as the result of an accident, an additional \$50,000 is paid to your beneficiary.
- Up to \$30,000 may be paid to you if you lose one or more limbs, or your eyesight, as the result of an accident.

YOUR BENEFITS AT A GLANCE

MEDICARE ELIGIBLE RETIREES AND MEDICARE ELIGIBLE DEPENDENTS UNDER PLAN L THROUGH KEYSTONE POINT OF SERVICE

If you are under the age of 65, in good standing with the Union, and not yet eligible for Medicare, you are eligible to continue your coverage under the Keystone POS program. If you're eligible for Medicare, the Fund offers a Medicare Supplement overage. See the section called “Retiree Benefits” for more information.

YOUR BENEFITS AT A GLANCE – PLAN NEP

A summary of your benefits appears below.

YOUR BENEFITS AT A GLANCE FOR PLANS NEP For Active Participants and their Eligible Dependents

Hospital and Medical Benefits

See your IBX-Personal Choice summary for more details. Generally, though:

- When you receive “in-network” services, there’s no annual deductible, coinsurance, or lifetime maximum, a \$15 copay for primary care office visits and a \$25 copay for specialist office visits. The copay for an emergency room visit is \$40, which is waived if you’re admitted to the hospital. For hospital admissions, there is a special copay of \$100 per day, up to a maximum of \$500 per admission (for up to 5 days). There is a \$28.00 copay for outpatient urgent care
- When you receive “out-of-network” services, you have an annual deductible of \$500 per person and \$1,000 per family, and 30% coinsurance. The Plan pays the remaining 70%.

Prescription Drug Benefits

Provided through Benecard:

- If you go “in-network” to a **participating pharmacy**, you have a \$15 copay for a generic drug and a \$25 copay for a brand name drug and you will receive up to a 30-day supply. Through the **participating pharmacy**, you will have a \$30 copay for a generic drug and a \$50 copay for a brand name drug and will receive up to a 90-day supply.
- If you go through the **mail order** service, you will have a \$30 copay for a generic drug and a \$50 copay for a brand name drug and will receive up to a 90-day supply.

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

Dental Benefits



Provided through Fidelio A Plan (“A Plan”):

- You have a choice of in-network or out-of-network dentists.
- The Plan has established a maximum allowable charge for each covered service.
- When you receive services **in-network**, the Plan pays a specified percentage of the allowable charge (for example, 90%) and your copay is the remaining percentage (for example, 10%).
- When you go **out-of-network**, the Plan pays the same amount (a specified percentage of the allowable charge) it would pay if you went in-network. You will be responsible for paying 100% of any amount the dentist charges above what the Plan pays.

The Plan provides an annual maximum for the plan year of \$1,500 per covered person for all covered dental services (except orthodontia, dental implants or Invisalign where separate benefit rules apply – see summary of benefits for A Plan).

The Plan will provide eligible participants and dependents age 19 or older an **in-network** orthodontic benefit of \$1,000 per lifetime OR an **out-of-network** orthodontic benefit of 50% of the dentist’s charges, up to a lifetime limit of \$500.

The Plan also provides an **in-network** orthodontic benefit of \$4,000 per lifetime OR an **out-of-network** benefit of 50% of the dentist’s charges up to \$2,000 per lifetime for eligible dependent children up to age 19.

Predetermination from Fidelio is required for certain orthodontic procedures above \$300.00 – see summary of benefits.

Vision Benefit

Provided through National Vision Administrators (“NVA”):

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

- Age 18 and under, one exam and lenses or contacts every 12 months, frames every 24 months,
- Age 19 and older, one exam and glasses (lenses and frames) or contact lenses every 24 months.

Weekly Disability Benefits (for Active Participants only)

Provided through the Fund Office:

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

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

Provided through Amalgamated Insurance Company (“Amalgamated”) and the Fund Office:

- \$50,000 is paid to your beneficiary if you die from any cause while covered by the Fund.
- If you die as the result of an accident, an additional \$50,000 is paid to your beneficiary.
- Up to \$30,000 may be paid to you if you lose one or more limbs, or your eyesight, as the result of an accident.

YOUR BENEFITS AT A GLANCE

For retirees under Age of 65 and their Eligible Dependents not eligible for Medicare

If you retire before the age of 65 and are in good standing with the Union, you will receive coverage under the IBX-Personal Choice.

If you’re eligible for Medicare, the Fund offers Medicare Supplement coverage.

See the section called “Retiree Benefits” for more information.

YOUR BENEFITS AT A GLANCE - PLAN SP

A summary of your benefits appears below.

**YOUR BENEFITS AT A GLANCE FOR PLAN SP
For Active Participants and their Eligible Dependents**

Hospital and Medical Benefits



See your IBX-Personal Choice summary for more details. Generally, though:

- When you receive “in-network” services, there’s no annual deductible, coinsurance, or lifetime maximum, a \$15 copay for primary care office visits and a \$25 copay for specialist office visits. The copay for an emergency room visit is \$40, which is waived if you’re admitted to the hospital. For hospital admissions, there is a special copay of \$100 per day, up to a maximum of \$500 per admission (for up to 5 days). There is a \$28.00 copay for outpatient urgent care
- When you receive “out-of-network” services, you have an annual deductible of \$500 per person and \$1,000 per family, and 30% coinsurance. The Plan pays the remaining 70%.

Prescription Drug Benefits

Provided through Benecard:

- If you go “in-network” to a **participating pharmacy**, you have a \$20 copay for a generic drug and a \$30 copay for a brand name drug and you will receive up to a 30-day supply. Through the **participating pharmacy**, you will have a \$40 copay for a generic drug and a \$60 copay for a brand name drug and will receive up to a 90-day supply.
- If you go through the **mail order** service, you will have a \$40 copay for a generic drug and a \$60 copay for a brand name drug and will receive up to a 90-day supply.

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

Dental Benefits

Provided through Fidelio A Plan (“A Plan”):

- You have a choice of in-network or out-of-network dentists.
- The Plan has established a maximum allowable charge for each covered service.
- When you receive services **in-network**, the Plan pays a specified percentage of the allowable charge (for example, 90%) and your copay is the remaining percentage (for example, 10%).
- When you go **out-of-network**, the Plan pays the same amount (a specified percentage of the allowable charge) it would pay if you went in-network. You will be responsible for paying 100% of any amount the dentist charges above what the Plan pays.

The Plan provides an annual maximum for the plan year of \$1,500 per covered person for all covered dental services (except orthodontia, dental implants or Invisalign where separate benefit rules apply – see summary of benefits for A Plan).

The Plan will provide eligible participants and dependents age 19 or older an **in-network** orthodontic benefit of \$1,000 per lifetime OR an **out-of-network** orthodontic benefit of 50% of the dentist’s charges, up to a lifetime limit of \$500.

The Plan also provides an **in-network** orthodontic benefit of \$4,000 per lifetime OR an **out-of-network** benefit of 50% of the dentist’s charges up to \$2,000 per lifetime for eligible dependent children up to age 19.

Predetermination from Fidelio is required for certain orthodontic procedures above \$300.00 – see summary of benefits.

Vision Benefit

Provided through National Vision Administrators (“NVA”):

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

- Age 18 and under, one exam and lenses or contacts every 12 months, frames every 24 months,
- Age 19 and older, one exam and glasses (lenses and frames) or contact lenses every 24 months.

Weekly Disability Benefits (for Active Participants only)

Provided through the Fund Office:

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

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



Provided through Amalgamated Insurance Company (“Amalgamated”) and the Fund Office:

- \$50,000 is paid to your beneficiary if you die from any cause while covered by the Fund.
- If you die as the result of an accident, an additional \$50,000 is paid to your beneficiary.
- Up to \$30,000 may be paid to you if you lose one or more limbs, or your eyesight, as the result of an accident.

YOUR BENEFITS AT A GLANCE

For retirees under Age of 65 and their Eligible Dependents not eligible for Medicare

If you retire before the age of 65 and are in good standing with the Union, you will receive coverage under the IBX-Personal Choice.

If you're eligible for Medicare, the Fund offers Medicare Supplement coverage.

See the section called “Retiree Benefits” for more information.



YOUR BENEFITS AT A GLANCE – PLANS T & X

A summary of your benefits appears below.

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

Hospital and Medical Benefits

Provided by Independence Blue Cross:

See your summary for more details. Generally, though:

- When you receive “**in-network**” services, there is a \$500 per person and \$1,500 per family deductible, 20% coinsurance, and no lifetime maximum. There is an out-of-pocket maximum of \$2,000 per participant and \$6,000 per family then the plan pays 20%.
- When you receive “**out-of-network**” services, you have an annual deductible of \$1,000 per person and \$3,000 per family deductible, 40% or 50% coinsurance, and no lifetime maximum. There is an out-of-pocket maximum of \$4,000 participant and \$12,000 per family, then the plan pays 40%.

Prescription Drug Benefits

Provided through Benecard:

- If you go “in-network” to a **participating pharmacy**, you have a \$20 copay for a generic drug and a \$30 copay for a brand name drug and you will receive up to a 30-day supply. Through the **participating pharmacy**, you will have a \$40 copay for a generic drug and a \$60 copay for a brand name drug and will receive up to a 90-day supply.
- Through the **mail order** service, you have a \$40 copay for a generic drug and a \$60 copay for a brand name drug and will receive up to a 90-day supply.

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

Dental Benefits

Provided through Fidelio A Plan (“A Plan”):

- You have a choice of in-network or out-of-network dentists.
- The Plan has established a maximum allowable charge for each covered service.
- When you receive services **in-network**, the Plan pays a specified percentage of the allowable charge (for example, 90%) and your copay is the remaining percentage (for example, 10%).
- When you go **out-of-network**, the Plan pays the same amount (a specified percentage of the allowable charge) it would pay if you went in-network. You will be responsible for paying 100% of any amount the dentist charges above what the Plan pays.

The Plan provides an annual maximum for the plan year of \$1,500 per covered person for all covered dental services (except orthodontia, dental implants or Invisalign where separate benefit rules apply – see summary of benefits for A Plan).

The Plan will provide eligible participants and dependents age 19 or older an **in-network** orthodontic benefit of \$1,000 per lifetime OR an **out-of-network** orthodontic benefit of 50% of the dentist’s charges, up to a lifetime limit of \$500.

The Plan also provides an **in-network** orthodontic benefit of \$4,000 per lifetime OR an **out-of-network** benefit of 50% of the dentist’s charges up to \$2,000 per lifetime for eligible dependent children up to age 19.

Predetermination from Fidelio is required for certain orthodontic procedures above \$300.00 – see summary of benefits.

Vision Benefit

Provided through National Vision Administrators (“NVA”):

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

- Age 18 and under, one exam and lenses or contacts every 12 months, frames every 24 months,
- Age 19 and older, one exam and glasses (lenses and frames) or contact lenses every 24 months.

Weekly Disability Benefits (for Active Participants only)



Provided through the Fund Office:

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

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

Provided through Amalgamated Insurance Company (“Amalgamated”) and the Fund Office:

- \$50,000 is paid to your beneficiary if you die from any cause while covered by the Fund.
- If you die as the result of an accident, an additional \$50,000 is paid to your beneficiary.
- Up to \$30,000 may be paid to you if you lose one or more limbs, or your eyesight, as the result of an accident.

YOUR BENEFITS AT A GLANCE

**NON-MEDICARE ELIGIBLE RETIREES AND DEPENDENTS
MEDICARE ELIGIBLE RETIREES AND MEDICARE ELIGIBLE DEPENDENTS UNDER
PLANS T & X**

ALL NON-MEDICARE ELIGIBLE RETIREES AND DEPENDENTS: If you are under the age of 65, in good standing with the Union, and not yet eligible for Medicare, you are eligible to receive coverage under Plans T&X.

MEDICARE ELIGIBLE RETIREES AND DEPENDENTS: If you're eligible for Medicare, the Fund offers a Medicare Supplement coverage.

See the section called “Retiree Benefits” for more information.



YOUR BENEFITS AT A GLANCE – PLANS Y & Z

A summary of your benefits appears below.

YOUR BENEFITS AT A GLANCE FOR PLANS Y & Z FOR ACTIVE PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS

Hospital and Medical Benefits

Provided by Independence Blue Cross:

See your summary for more details. Generally, though:

- When you receive “**in-network**” services, there is a \$1,200 per person and \$3,600 per family deductible, 20% coinsurance, and no lifetime maximum. There is an out-of-pocket maximum of \$3,000 per participant and \$9,000 per family then the plan pays 20%.
- When you receive “**out-of-network**” services, you have an annual deductible of \$2,400 per person and \$7,200 per family deductible, 40% or 50% coinsurance, and no lifetime maximum. There is an out-of-pocket maximum of \$6,000 participant and \$18,000 per family, then the plan pays 40%.

Prescription Drug Benefits

Provided through Benecard:

- If you go “in-network” to a **participating pharmacy**, you have a \$20 copay for a generic drug and a \$30 copay for a brand name drug and you will receive up to a 30-day supply. Through the **participating pharmacy**, you will have a \$40 copay for a generic drug and a \$60 copay for a brand name drug and will receive up to a 90-day supply.
- Through the **mail order** service, you have a \$40 copay for a generic drug and a \$60 copay for a brand name drug and will receive up to a 90-day supply.

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

Dental Benefits

Provided through Fidelio A Plan (“A Plan”):

- You have a choice of in-network or out-of-network dentists.
- The Plan has established a maximum allowable charge for each covered service.
- When you receive services **in-network**, the Plan pays a specified percentage of the allowable charge (for example, 90%) and your copay is the remaining percentage (for example, 10%).
- When you go **out-of-network**, the Plan pays the same amount (a specified percentage of the allowable charge) it would pay if you went in-network. You will be responsible for paying 100% of any amount the dentist charges above what the Plan pays.

The Plan provides an annual maximum for the plan year of \$1,500 per covered person for all covered dental services (except orthodontia, dental implants or Invisalign where separate benefit rules apply – see summary of benefits for A Plan).

The Plan will provide eligible participants and dependents age 19 or older an **in-network** orthodontic benefit of \$1,000 per lifetime OR an **out-of-network** orthodontic benefit of 50% of the dentist’s charges, up to a lifetime limit of \$500.

The Plan also provides an **in-network** orthodontic benefit of \$4,000 per lifetime OR an **out-of-network** benefit of 50% of the dentist’s charges up to \$2,000 per lifetime for eligible dependent children up to age 19.

Predetermination from Fidelio is required for certain orthodontic procedures above \$300.00 – see summary of benefits.

Vision Benefit

Provided through National Vision Administrators (“NVA”):

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

- Age 18 and under, one exam and lenses or contacts every 12 months, frames every 24 months,
- Age 19 and older, one exam and glasses (lenses and frames) or contact lenses every 24 months.

Weekly Disability Benefits (for Active Participants only)



Provided through the Fund Office:

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

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

Provided through Amalgamated Insurance Company (“Amalgamated”) and the Fund Office:

- \$50,000 is paid to your beneficiary if you die from any cause while covered by the Fund.
- If you die as the result of an accident, an additional \$50,000 is paid to your beneficiary.
- Up to \$30,000 may be paid to you if you lose one or more limbs, or your eyesight, as the result of an accident.

**YOUR BENEFITS AT A GLANCE
NON-MEDICARE ELIGIBLE RETIREES AND DEPENDENTS
MEDICARE ELIGIBLE RETIREES AND MEDICARE ELIGIBLE DEPENDENTS UNDER
PLANS Y & Z**

ALL NON-MEDICARE ELIGIBLE RETIREES AND DEPENDENTS: If you are under the age of 65, in good standing with the Union, and not yet eligible for Medicare, you are eligible to receive coverage under Plans T&X.

MEDICARE ELIGIBLE RETIREES AND DEPENDENTS: If you're eligible for Medicare, the Fund offers a Medicare Supplement coverage.
See the section called “Retiree Benefits” for more information.

Patient Protection and Affordable Care Act

The Board of Trustees believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.



ELIGIBILITY AND PARTICIPATION - PLANS A, B, E, F, G, N, HA, RES AND AP

Who Is Eligible To Participate?

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

- Active Participants
- Employees of the Union, Welfare Fund, Apprentice Fund and Plan RES Employers whose work is covered by a participation agreement with the Fund (also called “Active Non-Bargaining Unit Employees”)
- Retired employees (“Retirees”)
- Eligible Dependents.

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

Payment for Coverage

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

Benefit Levels

There are two levels of benefits under the Fund – The benefit level you qualify for depends on the number of hours you have worked and whether you are a Retiree or Active Participant.

- a higher level called Plan A, Plan E, Plan F or Plan RES, depending on which employment category you are in. The higher level of benefits (Plans A, E, F, and RES) is for Philadelphia Area Painters, Paperhangers and Drywall Finishers and Glazier employees who meet the hours requirement and are not out on disability leave, as well as Active Non-Bargaining Unit Employees. (Note that Plan RES, which is for certain wall-to-wall non-bargained Employees, is slightly different than Plans A, E, and F, as noted in the “Benefits At A Glance” at the beginning of this SPD.)
- a lower level called Plan B or Plan G depending on which employment category you are in. The lower level of benefits (Plans B, G, N, HA and AP) are Philadelphia Area Painters, Paperhangers and Drywall Finishers and Glazier employees and Apprentices who meet the lesser hours requirement or are out on disability leave. This level of benefits is also available to Retirees who are not eligible for Medicare.

These benefit levels are also available to Eligible Dependents, depending on the benefit level to which the Active Participant or Retiree is entitled.



Eligibility for Active Participants

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

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

When Coverage Starts for Active Participants

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

Requirements for Initial eligibility for Plans A, B, E, F, G, HA, N and AP

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

Requirements for Initial eligibility for Plan RES

You become a participant once contributions have been made on your behalf by your Employer to the Fund.

Requirements for Continued Eligibility

In order to maintain eligibility under the Plan, you must work the number of hours outlined according to the following schedules. The level of benefits available depends on the number of hours worked in Covered Employment except for Apprentices (AP or HA) which are only entitled to the lower level of benefits. If you work at least 700 hours during a work period, you will be eligible for the higher level of benefits (A, E and F). If you work at least 550 hours during a work period, you will be eligible for the lower level of benefits (B and G).

CONTINUING ELIGIBILITY FOR PHILADELPHIA AREA PAINTERS, PAPERHANGERS AND DRYWALL FINISHERS AND GLAZIERS

MINIMUM NUMBER OF HOURS WORKED FOR ELIGIBILITY – “PLAN A, E, AND F”		
If you work this many hours...	During this work period...	Then you are eligible for coverage during the following benefit period...
700 hours	January 1 – June 30	October 1 – March 31
700 hours	July 1 – December 31	April 1 – September 30



If you are not eligible for Plan A or F, you may be eligible for Plan B or G if you meet the following requirements.

MINIMUM NUMBER OF HOURS WORKED FOR ELIGIBILITY – “PLAN B, G, N, HA & AP”

If you work this many hours...	During this work period...	Then you are eligible for coverage during the following benefit period...
550 hours	January 1 – June 30	October 1 – March 31
550 hours	July 1 – December 31	April 1 – September 30

CONTINUING ELIGIBILITY FOR PLAN RES EMPLOYEES

You will continue to be covered under Plan RES if your employer makes the required monthly contributions to the Fund.

What Happens If You Do Not Work The Required Hours In A Work Period? If, after establishing your eligibility, you do not meet the hours requirement in a particular work period as outlined above, you may be eligible to continue coverage through the “Look-Back Rule,” the “Hours Bank” or through “Self-Payment,” as described in the following sections.

Look-Back Rule. If you fail to work the required hours in a work period, you can maintain your coverage through the “Look-Back Rule.” Under this rule, the Plan “looks back” to see if you worked 1400 hours (for the higher level of benefits) or 1100 hours (for the lower level of benefits) in the twelve consecutive month period ending with the last day of the work period in which you failed to work the required hours. The following table shows how this works.

CONTINUING ELIGIBILITY UNDER THE LOOK-BACK RULE

If you did not meet the hour requirement during the following work period...	Then the Fund will “look-back” to see if you met the 1400 (or 1100) hour requirement in preceding 12-month period...
July 1 – December 31	January 1 – December 31
January 1 – June 30	July 1 – June 30

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

Hours Bank. Another way to continue eligibility when you have not worked the minimum hours required and therefore, would not qualify for continued coverage under the Look-Back Rule is through the Hours Bank. In order to use your Hours Bank, you must have worked at least 160 hours in the Benefit Period. Under this feature, any hours that you accrue above 1,800-hour maximum that you work during a calendar year will be “deposited” in the bank for later use (April 1st of the following calendar year). Hours are deposited at the end of the calendar year in which they are earned. You can



use these banked hours to qualify for consecutive Benefit Periods, provided you worked at least 160 hours in each of the Benefit Periods. You may hold a maximum of 2,000 hours in the Hours Bank. You cannot use your Hours Bank for retiree coverage.

If you were originally eligible for the lower level of benefits (Plan B or Plan G), you cannot use the Hours Bank to “buy up” to receive Plan A, E or F level of benefits.

Forfeiture of hours. Your Hours Bank balance will be forfeited under the following circumstances:

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

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

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

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

Self-payment rates. Self-payment rates are set by the Board of Trustees and may be changed from time to time. Generally, the rate depends on the current contribution rate in the collective bargaining agreement. The Fund Office can provide you more information on the current self-pay rates. The Fund Office must receive your payment before the first day of the Benefit period for which it applies.

Eligibility for Non-Bargaining Unit Employees in Plans A, E or F

You are also eligible to participate in Plans A, E or F if you are employed by the Union, Welfare Fund, or Apprentice Fund, and your work is covered by a written participation agreement with the Fund.

When your coverage starts and ends. Your coverage begins on the first day of the month following 30 days of full-time employment, provided you submit the enrollment form in a timely fashion. **If you fail to submit the enrollment form, you may still be eligible for benefits, but your dependents will not be covered. Coverage for a Union, Welfare Fund or Apprentice Fund Employee will continue so long as the Employee remains so employed and contributions are made on the Employee’s behalf to the Fund.**



Eligibility for Retirees

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

- are receiving a normal, early, or disability pension benefit from the IUPAT Pension,
- are currently eligible for Fund benefits on the effective date of your pension,
- make the required monthly contributions to the Fund; and
- if you retired on or after April 1, 2015, you have maintained an active Union membership which remains in good standing.

Depending on whether you are eligible for Medicare, your age at time of retirement, whether you were receiving benefits under the Residential provision of the Plan and what kind of coverage you elect, your retiree benefits may differ from the standard Plan benefits that you received when you were an Active Participant. For information on benefits for Retirees and their Eligible Dependents, see the section called "Retiree Benefits."



ELIGIBILITY AND PARTICIPATION – PLAN L ONLY

Who Is Eligible To Participate?

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

- Active Participants
- Retired employees (“Retirees”)
- Eligible Dependents.

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

Payment for Coverage

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

Eligibility for Active Participants

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

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

Requirements for Initial Eligibility

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

Requirements for Continued Eligibility

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

CONTINUING ELIGIBILITY

MINIMUM NUMBER OF HOURS WORKED FOR ELIGIBILITY – “PLAN L”		
If you work this many hours...	During this work period...	Then you are eligible for coverage during the following benefit period...
700 hours	January 1 – June 30	October 1 – March 31
700 hours	July 1 – December 31	April 1 – September 30



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

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

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

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

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

Hours Bank. Another way to continue eligibility when you have not worked the minimum hours required and therefore, would not qualify for continued coverage under the Look-Back Rule is through the Hours Bank. In order to use your Hours Bank, you must have worked at least 160 hours in the Benefit Period. Under this feature, any hours that you accrue above 1,800-hour maximum that you work during a calendar year will be “deposited” in the bank for later use (April 1st of the following calendar year). Hours are deposited at the end of the calendar year in which they are earned. You can use these banked hours to qualify for consecutive Benefit Periods, provided you worked at least 160 hours in each of the Benefit Periods. You may hold a maximum of 2,000 hours in the Hours Bank. You cannot use your Hours Bank for retiree coverage.

Forfeiture of hours. Your Hours Bank balance will be forfeited under the following circumstances:

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

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



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

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

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

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

Eligibility for Retirees

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

- are receiving a normal, early, or disability pension benefit from the IUPAT Pension,
- are currently eligible for Fund benefits on the effective date of your pension,
- make the required monthly contributions to the Fund; and
- if you retired on or after April 1, 2015, you have maintained an active Union membership which remains in good standing.

Depending on whether you are eligible for Medicare and/or your age at time of retirement, your benefits may be different from the standard Plan benefits that you received when you were an Active Participant. For information on benefits for Retirees and their Eligible Dependents, see the section called “**Retiree Benefits.**”



ELIGIBILITY AND PARTICIPATION – PLANS NEP and SP

Who Is Eligible To Participate?

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

- Active Participants
- Retired employees (“Retirees”)
- Eligible Dependents.

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

Payment for Coverage

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

Eligibility for Active Participants

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

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

Requirements for Initial Eligibility

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

Requirements for Continued Eligibility

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

CONTINUING ELIGIBILITY

MINIMUM NUMBER OF HOURS WORKED FOR ELIGIBILITY – “PLANS NEP and SP”		
If you work this many hours...	During this work period...	Then you are eligible for coverage during the following benefit period...
700 hours	January 1 – June 30	October 1 – March 31
700 hours	July 1 – December 31	April 1 – September 30



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

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

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

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

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

Hours Bank. Another way to continue eligibility when you have not worked the minimum hours required and therefore, would not qualify for continued coverage under the Look-Back Rule is through the Hours Bank. In order to use your Hours Bank, you must have worked at least 160 hours in the Benefit Period. Under this feature, any hours that you accrue above 1,800-hour maximum that you work during a calendar year will be “deposited” in the bank for later use (April 1st of the following calendar year). Hours are deposited at the end of the calendar year in which they are earned. You can use these banked hours to qualify for consecutive Benefit Periods, provided you worked at least 160 hours in each of the Benefit Periods. You may hold a maximum of 2,000 hours in the Hours Bank. You cannot use your Hours Bank for retiree coverage.

Forfeiture of hours. Your Hours Bank balance will be forfeited under the following circumstances:

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

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



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

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

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

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

Eligibility for Retirees

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

- are receiving a normal, early, or disability pension benefit from the IUPAT Pension,
- are currently eligible for Fund benefits on the effective date of your pension,
- make the required monthly contributions to the Fund; and
- if you retired on or after April 1, 2015, you have maintained an active Union membership which remains in good standing.

Depending on whether you are eligible for Medicare and/or your age at time of retirement, your benefits may be different from the standard Plan benefits that you received when you were an Active Participant. For information on benefits for Retirees and their Eligible Dependents, see the section called “**Retiree Benefits.**”



ELIGIBILITY AND PARTICIPATION – PLANS T & X ONLY

Who Is Eligible To Participate?

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

- Active Participants
- Retired employees (“Retirees”)
- Eligible Dependents.

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

Payment for Coverage

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

Eligibility for Active Participants

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

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

When Coverage Starts for Active Participants

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

Requirements for Initial Eligibility

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

Requirements for Continued Eligibility

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



CONTINUING ELIGIBILITY

MINIMUM NUMBER OF HOURS WORKED FOR ELIGIBILITY – “PLANS T&X”		
If you work this many hours...	During this work period...	Then you are eligible for coverage during the following benefit period...
700 hours	January 1 – June 30	October 1 – March 31
700 hours	July 1 – December 31	April 1 – September 30

What Happens If You Do Not Work The Required Hours In A Work Period? If, after establishing your eligibility, you do not meet the hours requirement in a particular work period as outlined above, you may be eligible to continue coverage through the “Look-Back Rule,” the “Hours Bank” or through “Self-Payment,” as described in the following sections.

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

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

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

Hours Bank. Another way to continue eligibility when you have not worked the minimum hours required and therefore, would not qualify for continued coverage under the Look-Back Rule is through the Hours Bank. In order to use your Hours Bank, you must have worked at least 160 hours in the Benefit Period. Under this feature, any hours that you accrue above 1,800-hour maximum that you work during a calendar year will be “deposited” in the bank for later use (April 1st of the following calendar year). Hours are deposited at the end of the calendar year in which they are earned. You can use these banked hours to qualify for consecutive Benefit Periods, provided you worked at least 160 hours in each of the Benefit Periods. You may hold a maximum of 2,000 hours in the Hours Bank. You cannot use your Hours Bank for retiree coverage.

Forfeiture of hours. Your Hours Bank balance will be forfeited under the following circumstances:

- you leave Covered Employment and do not re-establish eligibility within 10 benefit periods (five years), or



- you are no longer represented by the “union” for employment purposes (for reasons other than disability or early retirement). The “union” includes District Council No. 21 and any other affiliate of the IUPAT.

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

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

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

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

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

Eligibility for Retirees

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

- are receiving a normal, early, or disability pension benefit from the IUPAT Pension,
- are currently eligible for Fund benefits on the effective date of your pension,
- make the required monthly contributions to the Fund; and
- if you retired on or after April 1, 2015, you have maintained an active Union membership which remains in good standing.

Depending on whether you are eligible for Medicare and/or your age at time of retirement, your benefits may be different from the standard Plan benefits that you received when you were an Active Participant. For information on benefits for Retirees and their Eligible Dependents, see the section called “Retiree Benefits.”



ELIGIBILITY AND PARTICIPATION – PLANS Y & Z ONLY

Who Is Eligible To Participate?

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

- Active Participants
- Retired employees (“Retirees”)
- Eligible Dependents.

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

Payment for Coverage

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

Eligibility for Active Participants

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

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

When Coverage Starts for Active Participants

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

Requirements for Initial Eligibility

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

Requirements for Continued Eligibility

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



CONTINUING ELIGIBILITY

MINIMUM NUMBER OF HOURS WORKED FOR ELIGIBILITY – “PLANS Y&Z”		
If you work this many hours...	During this work period...	Then you are eligible for coverage during the following benefit period...
550 hours	January 1 – June 30	October 1 – March 31
550 hours	July 1 – December 31	April 1 – September 30

What Happens If You Do Not Work The Required Hours In A Work Period? If, after establishing your eligibility, you do not meet the hours requirement in a particular work period as outlined above, you may be eligible to continue coverage through the “Look-Back Rule,” the “Hours Bank” or through “Self-Payment,” as described in the following sections.

Look-Back Rule. If you fail to work the required hours in a work period, you can maintain your coverage through the “Look-Back Rule.” Under this rule, the Plan “looks back” to see if you worked 1100 hours in the twelve consecutive month period ending with the last day of the work period in which you failed to work the required hours. The following table shows how this works.

CONTINUING ELIGIBILITY UNDER THE LOOK-BACK RULE	
If you did not meet the hour requirement during the following work period...	Then the Fund will “look-back” to see if you met the 1100-hour requirement in preceding 12-month period...
January 1 – June 30	July 1 – June 30
July 1 – December 31	January 1 – December 31

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

Hours Bank. Another way to continue eligibility when you have not worked the minimum hours required and therefore, would not qualify for continued coverage under the Look-Back Rule is through the Hours Bank. In order to use your Hours Bank, you must have worked at least 160 hours in the Benefit Period. Under this feature, any hours that you accrue above 1,800-hour maximum that you work during a calendar year will be “deposited” in the bank for later use (April 1st of the following calendar year). Hours are deposited at the end of the calendar year in which they are earned. You can use these banked hours to qualify for consecutive Benefit Periods, provided you worked at least 160 hours in each of the Benefit Periods. You may hold a maximum of 2,000 hours in the Hours Bank. You cannot use your Hours Bank for retiree coverage.

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

- you leave Covered Employment and do not re-establish eligibility within 10 benefit periods (five years), or



- you are no longer represented by the “union” for employment purposes (for reasons other than disability or early retirement). The “union” includes District Council No. 21 and any other affiliate of the IUPAT.

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

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

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

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

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

Eligibility for Retirees

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

- are receiving a normal, early, or disability pension benefit from the IUPAT Pension,
- are currently eligible for Fund benefits on the effective date of your pension,
- make the required monthly contributions to the Fund; and
- if you retired on or after April 1, 2015, you have maintained an active Union membership which remains in good standing.

Depending on whether you are eligible for Medicare and/or your age at time of retirement, your benefits may be different from the standard Plan benefits that you received when you were an Active Participant. For information on benefits for Retirees and their Eligible Dependents, see the section called “Retiree Benefits.”



Dependent Coverage

Coverage for your dependents generally starts at the same time as your coverage, so long as you file an enrollment form in a timely fashion with the Fund Office at 2980 Southampton-Byberry Road, Philadelphia, PA 19154.

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

“Eligible Dependents”

Your Eligible Dependents include:

- The spouse to whom you are married. Spouse is defined as:
 - “Spouse” shall mean the individual to whom a Participant is lawfully married under any state law. Effective June 26, 2013, a Spouse shall include an individual of the same sex who is legally married to the Participant in a state or legal jurisdiction that recognizes such marriages, even if they reside in a domestic or foreign jurisdiction that does not recognize the validity of same-sex marriage.
- Your child or children must be under twenty-six (26) years of age, and is defined as:
 - Your natural born child or the natural born child of your spouse regardless of where or with whom the child lives;
 - Your stepchild so long as you and the child’s natural parent remain married;
 - Your foster child;
 - A child who is: (a) legally adopted by you, or your spouse, or (b) placed with you, or your spouse, for adoption;
 - You or your spouse’s legal ward (but not your foster child) who: (a) resides with you in a regular parent-child relationship; (b) is chiefly dependent on you for support and maintenance; and (c) is unmarried;
 - You or your spouse’s unmarried grandchild for whom you have court-ordered custody; or
 - A child that the Plan is required to cover under the terms of a Qualified Medical Child Support Order (“QMCSO”).

In general, coverage will end the first day of the month following the Dependent child’s 26th birthday.

When you enroll a dependent you will be asked to provide proof of dependent status — for example, a birth certificate, a marriage certificate, a copy of the dependent’s Social Security card and any other pertinent proof of dependent status.

New dependents. If you have a child by birth, adoption, or placement for adoption, the child will be covered from the date of the birth, adoption, or placement, provided you file the enrollment form at the Fund Office within 31 days of the birth/adoption/placement. If you get married, your spouse will be covered starting on the first day of the month following the month in which you got married, so long as you file an application for to enroll your spouse. If



you do not complete the application within 31 days from the date of the acquisition, coverage for your dependents will be delayed.

About QMCSOs. A Qualified Medical Child Support Order, or QMCSO, is an order issued by a court or state administrative agency that requires that medical coverage be provided under a plan for a child or children. A QMCSO usually results from either a divorce, legal separation or paternity proceeding. If a QMCSO requires the Plan to provide your child(ren) with health coverage, then the Plan, upon determination that the QMCSO is valid, must provide the child(ren) with health coverage, including a child(ren) that: do not reside with you and for whom you do not provide financial support; are born out of wedlock; and those whom you do not claim as a dependent on your federal tax return. The order, however, cannot require the Plan to provide any type or form of benefit coverage, or any option for benefit coverage, not otherwise available under the Plan for dependents of the participant, or to provide increased benefits of any type.

The Fund Office will notify you if a QMCSO is received regarding your coverage. In order for the Fund to recognize a QMCSO, the order must specifically identify the name of this Plan and must contain the following information:

- the name and last-known mailing address (if any) of the participant and each child covered by the order;
- a reasonable description of the type of benefit coverage to be provided by the Plan, or the manner in which such coverage is to be determined; and
- the time period to which such order applies.

If you, your child, or the child's custodial parent or legal guardian have questions related to QMCSOs and how they are handled by the Plan, please contact the Fund Office.

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

TERMINATION OF COVERAGE AND COBRA COVERAGE RIGHTS

When Coverage Ends:

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

- the last day of the last Benefit period for which you qualify for benefits,
- the 31st day of active military duty for the United States or such later date as required by applicable law,
- the date your employment category is no longer covered by a collective bargaining agreement or participation agreement,



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

For Retirees. Your coverage ends if:

- you stop paying the required premiums for continued coverage
- you do not properly waive coverage for yourself or your Dependents,
- if you retire on or after April 1, 2015, and you do not maintain an active Union membership in good standing, or
- the Plan is terminated or no longer covers Retirees.

For dependents. Coverage for your dependents ends if:

- you, the participant, dies*,
- your coverage ends,
- they no longer meet the definition of “Eligible Dependent,” (e.g., the Active Participant divorces the parent of the step-children, those step-children, upon proof of divorce, are no longer eligible for plan coverage)
- they become covered under the Plan as Active Participants,
- in the case of a Retirees, the required premium for Dependents is not paid,
- the Plan cancels dependent coverage, or
- the Plan terminates.

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

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

When your coverage under the Plan would otherwise end, you may be eligible for the continuation of coverage by electing through either COBRA Continuation Coverage (which is discussed in more detail later in this Section), the obtaining coverage via the Health Insurance Marketplace through www.healthcare.gov during your sixty (60) – day special enrollment period, or if you and/or your dependent is disabled, you may qualify for Medicaid (please verify Medicaid application requirements for the state where you and/or your dependent is a resident). Also, the Plan also has rules for limited extensions of coverage during certain absences which is described immediately below.

Continuation of Coverage During Certain Absences

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



If you take an FMLA leave, your employer is obligated to continue contributions to the Fund on your behalf so that your coverage through the Fund remains in effect.

During your leave, the coverage provided by the Fund will be maintained at the level of coverage you and your dependents had in place at the time your leave began. You are commonly eligible for an FMLA leave if you provide certification for the reason(s) that require your leave under FMLA and you:

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

If you do not return to employment following your FMLA leave during which coverage was provided, you may be required to provide reimbursement for the cost of coverage received during the leave. Additionally, if at the end of your FMLA leave, you do not return to work, you may be eligible to continue coverage under COBRA.

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

Note that, for leaves of absence covered by the FMLA, your employer must properly grant the leave and provide required notification and any required payment to the Fund. You should contact your employer to confirm that you are eligible for leave.

Military Leave. If you are on active military duty for less than 31 days, you will continue to receive health care coverage from the Fund in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), 38 U.S.C. §§ 4301 *et seq.* If you are on active duty for 31 days or more, your Fund coverage ends, but USERRA permits you to continue health care coverage for you and your dependents at your own expense for up to 18 months (24 months for participants electing coverage on or after December 10, 2004). This continuation right operates in a similar fashion to coverage under COBRA, which is described in the next section. In addition, your dependent(s) may be eligible for health care coverage under the federal program known as TRICARE (which includes the old "CHAMPUS" program). This Plan coordinates its coverage with TRICARE pursuant to the Plan's Coordination of Benefits Rules. **However, please note that should you elect to continue coverage under USERRA, you are not permitted to elect to extend your coverage through COBRA once your coverage under USERRA ends.**

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

- 90 days of the date of discharge, if the period of service is more than 180 days;
- 14 days from the date of discharge, if the period of service was 31 days or more but less than 181 days; or



- one day after discharge (allowing 8 hours for travel) if the period of service was less than 31 days.

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

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

Please note that, for leaves of absence for qualified military service that is covered pursuant to USERRA, your employer must properly grant the leave and provide required notification and make the appropriate contribution payment to the Fund on your behalf for the period for which your active military service that is thirty-one (31) days or less. You should also attempt to contact your employer to advise of your pending service, if possible.

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

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

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

Notice of COBRA Continuation Coverage Rights

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”), requires that this plan offer you and your eligible dependents (such as your spouse, former spouse, and/or dependent children) the opportunity for a temporary extension of health care coverage at group rates in certain instances when coverage under the plan would otherwise end (called “qualifying events”). Continued coverage under COBRA applies to **only** the medical, hospital, prescription drug, dental and vision benefits described in this booklet. COBRA is inapplicable to all other benefits discussed within this booklet, such as life insurance, accidental death, and weekly disability.

The benefits under COBRA are the same as those covering people who are not on continuation coverage. You should keep in mind that each individual entitled to coverage as the result of a qualifying event has a right to make his or her own election of coverage. For example, your spouse or other Eligible Dependent may elect COBRA coverage even if you do not. Please review the section titled “**Who can provide notice?**” below for more information.



If you have questions about COBRA you should contact:

**IUPAT District Council No. 21 Welfare Fund
 2980 Southampton-Byberry Road
 Philadelphia, PA 19154
 Phone: 800-252-7252/215-934-5130
 Fax: 215-934-5418**

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

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

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

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

Proof of good health is NOT required for COBRA coverage.

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



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

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

This extended period of COBRA continuation coverage is **not** available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of coverage is available to any child(ren) born to, adopted by, or placed for adoption with you during the 18-month period of continuation coverage.

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

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

Your employer is responsible for notifying the Fund Office within thirty (30) days after the date of one of the following events: your death; termination of employment, or the reduction in your hours of employment; or employer bankruptcy. (However, you or your family should also notify the Fund Office if such an event occurs in order to avoid confusion as to your status.)

You or your eligible dependents are responsible for informing the Fund Office of a divorce or a child's loss of their dependent status under the Plan within 60 days of the event (and do not forget to provide address for both you and the dependent(s)). If you do not notify the Fund by the end of that period, your dependents will not be entitled to continuation coverage, and the Fund may seek reimbursement for any benefits provided during any period of ineligibility.

The Fund must notify you and/or your Eligible Dependents of your right to COBRA coverage by sending an Election Notice within 14 days after it receives notice or becomes aware that a qualifying event has occurred. You will have 60 days from the date of your coverage termination or the date the COBRA notice is provided, whichever is later, to notify the Fund if you want to continue coverage through election of COBRA.

Where you or your dependents have provided notice to the Fund of a divorce, a beneficiary ceasing to be covered under the plan as a dependent, or a second qualifying event, but you are not in fact entitled to COBRA, the Fund will send you a written notice stating the reasons for the Fund's denial due to the unavailability of continuation coverage for the individual under COBRA within fourteen (14) days after receipt of the election notice.



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

- Divorce from your spouse.**
- A child no longer satisfies the eligibility requirements for coverage under the Plan.
- A second qualifying event occurs after a qualified beneficiary has begun their 18-month maximum period of continuation coverage under COBRA. This second qualifying event could include an employee's death, divorce or legal separation, or a child losing dependent status. *Please note: the second event will be considered a second qualifying event only if it would have caused a qualified beneficiary to lose their coverage under the plan in the absence of the first qualifying event.*

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

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

****Please note that, in the instance of you and your spouse divorce, if you both receive coverage through this Plan, you are advised that the Plan's health insurance benefits cannot be a part of your property settlement agreement. Your property settlement agreement can only state which person is responsible for paying for it. Thus, once the divorce is finalized, the former spouse who is not an Active Participant of this Plan will receive a COBRA notice and it will be the responsibility of the former spouse to make payment of the premium. Please contact the Fund Office if you desire to proceed with COBRA Continuation Coverage. Provision of a COBRA notice does not impact any QMCSO entered by a Court or State Agency (and recognized by the Plan) that pertains to a child's health coverage.**

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

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

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

Please include the following in your notice:

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



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

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

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

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

Note that each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA continuation coverage. However, despite each individual's independent right to elect coverage on their own, you (and your spouse) can elect continuation coverage on behalf of all other qualified beneficiaries for the same qualifying event. Further, in addition, a parent or legal guardian can elect continuation coverage for a minor child.

Keep the Fund Informed of Address Changes

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

Can you waive coverage? You may waive COBRA coverage during the election period if you so choose. Should you change your mind and want to revoke your waiver of COBRA coverage and elect to obtain COBRA benefits, you may do so as long your revocation occurs before the end of the election period, which is no later than **60 days after the later of** (1) the date of the relevant qualifying event; or (2) the date upon which coverage would be lost under the plan as a result of the qualifying event. Upon revocation of your waiver, the Plan is permitted to make coverage begin on the date the revocation is received.

Paying for COBRA coverage. You have to pay the full cost of continued coverage as calculated under COBRA (with the maximum premium charge to be no greater than 102% of the full cost). If you are eligible for 29 months of continued coverage due to disability, the law permits the



Fund to charge 150% of the full cost of the Plan during the 19th to 29th months of coverage. It is easiest to make your first payment when you file your COBRA election form, that is, within 60 days from the date your Plan coverage would otherwise end. In no event may your first payment be made later than 45 days after you mail in your signed election form to the Fund Office. If you fail to make the payment in full before the initial 45-day period, the Plan can terminate your right to COBRA benefits. All subsequent payments will be due on the last day of each month for the following month's coverage. You will be notified by the Fund Office if the amount of your monthly payment changes. In addition, if the benefits change for active employees, your coverage will change as well.

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

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

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

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

Impact of USERRA. Please note that, if you are a reservist and eligible for extended coverage under either COBRA or USERRA, if you elect coverage under USERRA, you cannot elect COBRA once your coverage under USERRA ends. Conversely, if you elect continuation coverage under COBRA, once your coverage ends, you cannot elect coverage under USERRA.

Unavailability of Continuation Coverage

Other coverage options. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family that are cheaper than the continuation cover such as the Health Insurance Marketplace, Medicaid, or during a "special enrollment period" with another group health plan coverage option (such as your spouse's plan). Should you qualify for the "special enrollment period" of another plan for which you are eligible, you must request enrollment within sixty (60) days from the loss of your job-based coverage. Also, in the Health Insurance Marketplace, you can compare available private health insurance options and see what



your premium, deductibles, and out-of-pocket expenses could be before you formally decide to enroll in a particular insurance coverage. You can learn more about other health insurance coverage options available, and whether you are eligible for a tax credit that may lower your coverage costs, through the Health Insurance Marketplace's website at www.healthcare.gov.

Should you desire to apply for Medicaid coverage for you and/or your dependent(s), please check the disability and/or income requirements with a Medicaid agency for the state where you and your family reside to see if you qualify for Medicaid.

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

Also under the Trade Act, eligible individuals can either take a tax credit or get advance monthly payment paid directly to the health plan administrator of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at <http://www.doleta.gov/tradeact/>.



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

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

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

- Changes in family status - New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.
 - If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, coverage will be effective the first of the month following your request for enrollment.
 - *Special Rule for Newborn or Newly Adopted Children: Contact the Fund as soon as possible to find out what is required for enrollment of the newborn and/or newly adopted child. As long as you enroll the child within 30 days of birth, adoption or placement for adoption, coverage should go into effect as of the date of birth for the newborn or within 31 days of the adoption or placement for adoption.*
- You previously stated in writing that you and or your dependents were waiving Fund coverage because of coverage under another medical plan, and that other coverage is lost for any of the following reasons:
 - termination of employment;
 - reduction in hours worked;
 - your spouse dies;
 - you and your spouse divorce or legally separate;
 - the other coverage was COBRA continuation coverage, and you or your dependent reaches the maximum length of time for COBRA continuation coverage; or
 - the other plan terminates because the employer [or other sponsor] did not pay the premium when due.

Under these circumstances, coverage shall take effect on the first day of the month following the month in which your other coverage requires amendment or were terminated, provided that coverage is requested within 31 days of the applicable event.

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

Certificate of Creditable Coverage. When your Fund coverage ends, you and/or your dependents will be provided with a “Certificate of Creditable Coverage.” Certificates of Creditable Coverage indicate the period of time you and/or your dependents were covered under the Fund (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you are covered under a health insurance policy, within 63 days after your coverage under this Fund ends (including



COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to you and/or your dependents under the new group health plan or health insurance policy, or if you are about to join a Medicare Drug Plan, avoid payment of a higher premium.

The Certificate of Creditable Coverage will be provided to you:

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

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

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

Conversion Privilege

When your Fund coverage ends, including COBRA coverage, you and/or your Eligible Dependents may be entitled to convert your medical coverage to individual contracts with Keystone or through the Health Insurance Marketplace. You generally have a limited number of days to exercise this right. For more information, you may review your medical benefits summary, call Keystone or visit the Health Insurance Marketplace website at www.healthcare.gov.

For information on converting your life insurance coverage, see the section on those benefits.

Medicaid and Children's Health Insurance Program (CHIP)

Loss of Eligibility for Medicaid or CHIP. If you and/or your dependents (including your spouse) are eligible, but not enrolled, for coverage under the Plan while receiving coverage from Medicaid or your state's CHIP in effect, you may be able to enroll yourself and your dependents in Plan coverage if you and/or your dependents lose eligibility from coverage under either program. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or CHIP. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

Eligibility for Medicaid or CHIP. If you and/or your dependents (including your spouse) are eligible for coverage under this Plan, and your state maintains a premium assistance subsidy program for either Medicaid and/or CHIP, you may be eligible to use funds from your (or your dependent's) enrollment in that premium assistance subsidy program to help you pay for Plan coverage for yourself and your dependents. If you are so eligible, your employer must allow you and/or your dependents to enroll in the Plan. However, you must request enrollment within 60 days after your or your dependents' determination of assistance eligibility. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. If you or your dependents are not enrolled in Medicaid and/or CHIP, and



you believe that you or any of your dependents are eligible, contact your state Medicaid or CHIP office to find out how to apply.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility:

Delaware

Medicaid

<https://assist.dhss.delaware.gov/>

Medicaid Health Benefit Manager

1-800-996-9969

CHIP

Delaware Healthy Children Program

<http://dhss.delaware.gov/dhss/dmma/dhcp.html>

1-800-996-9969

New Jersey

Medicaid:

<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

609-631-2392_

CHIP

<http://www.njfamilycare.org/index.html>

1-800-701-0710

Pennsylvania

Medicaid

<http://www.dhs.pa.gov/provider/medicalassistance/>

[healthinsurancepremiumpaymenthipprogram/index.htm](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthipprogram/index.htm)

1-800-692-7462

CHIP

<http://www.chipcoverspakids.com/Pages/default.aspx>

1-800-986-5437



HOSPITAL AND MEDICAL BENEFITS - PLANS A, B, E, F, G, N, HA, RES, AND AP

The benefits described in this section are available to Active Participants, Eligible Dependents, and Retirees under the age of 65 years of age who are ineligible for Medicare (excluding those individuals who retired receiving Residential benefits under the Plan and who are not eligible for Medicare).

Note that there are two levels of hospital and medical benefits: a higher level (Plans A, E, F and RES) and a lower level (Plans B, N, G, HA and AP).

- Plans A, E, F and RES - If you are an Active Participant (or an Eligible Dependent of an Active Participant), you may be eligible for the higher benefits depending on your hours of work.
- Plans B and G are for former Active Participants from Plans A and F (or participants with fewer work hours), and their Eligible Dependents, who meet the hours requirement for Plan B or Plan G, or who are out on disability. This coverage is also for Retirees under the age of 65 and their Eligible Dependents who are not eligible for Medicare.
- Plan N is for Delaware Painters contribution rate.
- Plan HA & AP is for Apprentices.

For information on Plan eligibility, see the section called “Eligibility and Participation.”

Personal Choice

Your hospital and medical benefits are provided through insurance policies purchased from QCC Insurance Company, a subsidiary of Independence Blue Cross (“Blue Cross”). The Plan provides a comprehensive Personal Choice program – ranging from office visits, to lab tests and X-rays, to major surgery and hospital care.

IMPORTANT: The actual insurance policy issued by QCC Insurance Company is what controls the hospital and medical benefits offered under this Plan. If there is a conflict between the contents of this Summary Plan Description (“SPD”) and the insurance policy issued by QCC Insurance Company, then the insurance policy shall control. You can contact the Fund Office if you would like to review a copy of the QCC insurance policy.

Under Personal Choice both in-network (“PPO”) and out-of-network (“non-PPO”) services are available. In-network and out-of-network services are explained in more detail later in this section. There is also a chart highlighting your main Personal Choice benefits.

Your benefits are also described in the description of benefits provided by Personal Choice. **That information (including any updates) should be considered part of, and kept with, this summary plan description (“SPD”).** The Personal Choice summary has important information, written in everyday language, on:

- **the full extent of your benefits** (including the methods used to determine whether new treatments and procedures are covered)



- **procedures to be followed to get benefits** (for example, preauthorizations, approvals, utilization reviews, out-of-area services, filing a claim for benefits, etc.)
- **limitations on benefits** – including excluded services and benefits, limits on number of visits, limits on the selection of primary care providers or providers of specialty care
- **claims review procedures** – that is, the procedures to follow if you want to appeal a claim for benefits that was denied either before or after the services were rendered (including claims for “urgent care”)
- **the circumstances in which your plan benefit could be reduced** if you have a right to sue or are entitled to reimbursement for your medical expenses from a third party
- **plan definitions**, including important terms such as “Medically Necessary”
- **privacy practices** - that is, how Personal Choice handles participants’ personal health information.

If you do not have a summary of Personal Choice benefits, call the Fund Office. If you have a question that the summary does not answer, call Personal Choice at 1-800-626-8144 (outside Philadelphia) or 1-215-557-7577 (Philadelphia area). You can also get more information online at www.ibx.com.

More About In-Network and Out-of-Network Services

In-network services are services provided by doctors, hospitals, and other health care facilities/professionals that have been selected by Personal Choice to provide services to members. These providers are called “participating” providers. Some of the key features of **in-network** services include:

- The ability to choose from an extensive network of providers;
- The freedom to use a specialist without a referral;
- No deductible, coinsurance, or lifetime maximum;
- A small copay for office visits and many other services;
- No claim forms to file.

A “copay” is a fixed fee that you must pay for specific medical services covered by the Plan, such as office visits to your doctor.

Out-of-network services are services provided by a licensed provider outside of the Personal Choice network. When you select out-of-network services that are covered by the Plan:

- You are responsible for an annual deductible and coinsurance on each covered service, plus any amount above the Plan Allowance;
- You will usually have to pay the provider up front when you receive the service;
- You will need to file a claim form to be reimbursed by Personal Choice.



A “deductible” is an annual amount that you have to pay before the Plan pays any benefits. After you have met the annual deductible, the “coinsurance” is the percentage you have to pay for covered services. Under this plan the coinsurance is 30%. The “Plan Allowance” is the maximum charge Personal Choices recognizes under the Plan for a specific service, treatment or supply. You are responsible for any difference between the Plan Allowance and the actual charge.

Example: Suppose that you go to a doctor in the Personal Choice network. You pay a \$10 copay and the Plan pays the balance – there is no other cost to you.

Suppose you instead sought out-of-network care for the same problem, and the out-of-network doctor charged you \$125. However, the Plan Allowance for the service is \$50, not \$125.

Assuming that you have already met your annual out-of-network deductible of \$300, the Plan pays 70% of \$50, or \$35, and you will pay \$15 as coinsurance. You will also be responsible for the \$75 the doctor charged that exceeded the Plan Allowance, so the total amount you will be required to pay out-of-pocket for this service is \$90. There could be substantial out-of-pocket expenses incurred by utilizing the out-of-network service.

***Finding an in-network provider.** The Fund Office will give you a copy of the Personal Choice provider directory free of charge. You can also call Personal Choice directly at 1-800-ASK-BLUE or look on their web site at www.ibx.com.*

Highlights of Your Benefits

The following table summarizes the benefits covered by your plan and shows you how much, if anything, you will be required to contribute to the cost of your medical care.

Medical Benefit Highlights

IUPAT DC #21

Covered Services	Your Costs (You pay)	
	In-Network	Out-of-Network
Benefits per Calendar Year		
Deductible (Embedded) ¹ Individual/Family	\$0/\$0	\$300/\$600
Out-of-Pocket Maximum (Embedded) ² Individual/Family	\$0/\$0	\$2,000/\$4,000
Coinsurance	0%	30%
Preventive Services		
Preventive Care	No charge	30% no deductible
Preventive Colonoscopy		
Preventive Plus Providers	No charge	Not covered
Hospital Based	No charge	30% no deductible
Physician Services		
Primary Care Physician (PCP) Office Visit	\$10	30% after deductible
Specialist Office Visit	\$20	30% after deductible
Retail Health Clinic Visit	\$10	30% after deductible
Telemedicine	Not covered	Not covered
Urgent Care Visit	\$28	30% after deductible
Therapy Services		
Physical Therapy (60 visits/year) ³		
Freestanding	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Hospital Based	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Occupational Therapy (60 visits/year) ³		
Freestanding	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Hospital Based	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Speech Therapy (60 visits/year) ³	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Emergency Services		
Emergency Room (copay waived if admitted)	\$40	Covered at In-Network level
Emergency Ambulance	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	30% after deductible

Reference ID: ULOI05012020

Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year) ⁴	\$75/Day; max of 5 copays per admission	30% after deductible
Observation Services	\$40	30% after deductible
Maternity Hospital Services ⁴	\$75/Day; max of 5 copays per admission	30% after deductible
Inpatient Professional Services (includes Maternity)	No charge	30% after deductible
Outpatient Surgery	In-Network	Out-of-Network
Freestanding	\$75	30% after deductible
Hospital Based	\$75	30% after deductible
Outpatient Professional Services	No charge	30% after deductible
Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	\$20	30% after deductible
Routine Radiology (X-Ray)		
Freestanding	\$20	30% after deductible
Hospital Based	\$20	30% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	\$20	30% after deductible
Hospital Based	\$20	30% after deductible
Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	No charge	30% after deductible
Hospital Based	No charge	30% after deductible
Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (30 visits/year) ⁵	\$20	30% after deductible
Acupuncture (18 visits/year) ⁵	\$20	30% after deductible
Standard Injectables	No charge	30% after deductible
Allergy Injections	No charge	30% after deductible
Biotech/Specialty Injectables		
Home/Office	No charge	30% after deductible
Outpatient	No charge	30% after deductible
Chemotherapy	No charge	30% after deductible
Dialysis	No charge	30% after deductible
Skilled Nursing Facility (120 days/year) ⁵	No charge	30% after deductible
Home Health	No charge	30% after deductible
Hospice	No charge	30% after deductible
Durable Medical Equipment (DME)	\$20	30% after deductible

Mental Health – Outpatient (includes serious mental illness and substance abuse)	\$20	30% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse) ⁴	\$75/Day; max of 5 copays per admission	30% after deductible

- 1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.
- 2 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.
- 3 Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Therapy combined visit limit in and out-of-network.
- 4 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.
- 5 Combined in and out-of-network.

The Personal Choice® Preferred Provider Organization (PPO) gives you freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by accessing care through Personal Choice's network of hospitals, doctors, and specialists, or by accessing care through preferred providers who participate in the BlueCard® PPO program. If you access care from a provider who does not participate in our network, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

This summary represents only a partial listing of benefits and exclusions of the Medical Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/LGBooklet or call 1-800-ASK-BLUE (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to <http://www.ibx.com/preapproval> or call the phone number that is listed on the back of your identification card.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetztscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス(無料)をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódíílnih koji' 1-800-275-2583.

Urdu:

توجه درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian:

សូមមេត្តាចាត់អារម្មណ៍: ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Medical Benefit Highlights

IUPAT DC #21

Covered Services	Your Costs (You pay)	
	In-Network	Out-of-Network
Benefits per Calendar Year		
Deductible (Embedded) ¹ Individual/Family	\$0/\$0	\$500/\$1,000
Out-of-Pocket Maximum (Embedded) ² Individual/Family	\$0/\$0	\$3,000/\$6,000
Coinsurance	0%	30%
Preventive Services		
Preventive Care	No charge	30% no deductible
Preventive Colonoscopy		
Preventive Plus Providers	No charge	Not covered
Hospital Based	No charge	30% no deductible
Physician Services		
Primary Care Physician (PCP) Office Visit	\$15	30% after deductible
Specialist Office Visit	\$25	30% after deductible
Retail Health Clinic Visit	\$15	30% after deductible
Telemedicine	Not covered	Not covered
Urgent Care Visit	\$28	30% after deductible
Therapy Services		
Physical Therapy (60 visits/year) ³		
Freestanding	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Hospital Based	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Occupational Therapy (60 visits/year) ³		
Freestanding	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Hospital Based	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Speech Therapy (60 visits/year) ³	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Emergency Services		
Emergency Room (copay waived if admitted)	\$40	Covered at In-Network level
Emergency Ambulance	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	30% after deductible

Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year) ⁴	\$100/Day; max of 5 copays per admission	30% after deductible
Observation Services	\$40	30% after deductible
Maternity Hospital Services ⁴	\$100/Day; max of 5 copays per admission	30% after deductible
Inpatient Professional Services (includes Maternity)	No charge	30% after deductible
Outpatient Surgery	In-Network	Out-of-Network
Freestanding	\$100	30% after deductible
Hospital Based	\$100	30% after deductible
Outpatient Professional Services	No charge	30% after deductible
Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	\$25	30% after deductible
Routine Radiology (X-Ray)		
Freestanding	\$25	30% after deductible
Hospital Based	\$25	30% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	\$25	30% after deductible
Hospital Based	\$25	30% after deductible
Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	No charge	30% after deductible
Hospital Based	No charge	30% after deductible
Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (30 visits/year) ⁵	\$25	30% after deductible
Acupuncture (18 visits/year) ⁵	\$25	30% after deductible
Standard Injectables	No charge	30% after deductible
Allergy Injections	No charge	30% after deductible
Biotech/Specialty Injectables		
Home/Office	No charge	30% after deductible
Outpatient	No charge	30% after deductible
Chemotherapy	No charge	30% after deductible
Dialysis	No charge	30% after deductible
Skilled Nursing Facility (120 days/year) ⁵	No charge	30% after deductible
Home Health	No charge	30% after deductible
Hospice	No charge	30% after deductible
Durable Medical Equipment (DME)	\$25	30% after deductible

Mental Health – Outpatient (includes serious mental illness and substance abuse)	\$25	30% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse) ⁴	\$100/Day; max of 5 copays per admission	30% after deductible

- 1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.
- 2 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.
- 3 Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Therapy combined visit limit in and out-of-network.
- 4 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.
- 5 Combined in and out-of-network.

The Personal Choice® Preferred Provider Organization (PPO) gives you freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by accessing care through Personal Choice's network of hospitals, doctors, and specialists, or by accessing care through preferred providers who participate in the BlueCard® PPO program. If you access care from a provider who does not participate in our network, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



HOSPITAL AND MEDICAL BENEFITS – PLAN L ONLY

FOR PLAN L ONLY: The Fund has entered into a contract of insurance with QCC Insurance Company and Keystone Health Plan East to provide the Keystone Point of Service C3F4O2 to benefits to all Active Members, Retirees who are under the age of 65 and are non-Medicare eligible, and their Eligible Dependents. For the individuals residing in the coverage area and under this program the plan is the Keystone Health Plan East. Keystone Point of Service benefits booklets and information are available through the Fund office, and include a comprehensive description of benefits, exclusions, limitations, and claims and appeals procedures.

Keystone Point of Service Primary Care Provider Details

1. Members must select a Primary Service Provider (PCP) who will serve as a gatekeeper for all medical services under this medical plan, excluding emergency care. Selection of the Primary Care Provider requires a ten-digit provider number available from the provider's office or online using the search options available at http://www.ibx.com/find_a_provider. The Primary Care Provider must be approved by the Keystone Health Plan. Each family member can utilize a different Primary Care Provider.
2. Keystone Health Plan East requires referrals from the PCP to access Specialist medical care.
3. Changes in the PCP are the member's responsibility and can be done by contacting Independence Blue Cross at the number found on the back of their insurance card. Additional information on PCP changes can be found online at www.ibx.com.

If you do not have a summary of Keystone benefits, call the Fund Office. If you have a question that the summary does not answer, call 1-800-626-8144 (outside Philadelphia) or 1-215-557-7577 (Philadelphia area). You can also get more information online at www.ibx.com.

Filing a Claim

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

Medical Benefit Highlights

Keystone Point-of-Service C3-F4-02 IUPAT DC #21

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	Referred	Self-Referred
Deductible (Embedded) ¹ Individual/Family	\$0/\$0	\$1,500/\$4,500
Out-of-Pocket Maximum (Embedded) ² Individual/Family	\$0/\$0	\$10,000/\$30,000
Coinsurance	0%	50%
<hr/>		
Preventive Services	Referred	Self-Referred
Preventive Care	No charge	50% no deductible
Preventive Colonoscopy Preventive Plus Providers	No charge	Not covered
Hospital Based	No charge	50% no deductible
<hr/>		
Physician Services	Referred	Self-Referred
Primary Care Physician (PCP) Office Visit	\$20	50% after deductible
Specialist Office Visit	\$40	50% after deductible
Retail Health Clinic Visit	\$20	50% after deductible
Telemedicine	Not covered	Not covered
Urgent Care Visit	\$70	50% after deductible
<hr/>		
Therapy Services	Referred	Self-Referred
Physical Therapy (Referred: 30 visits/year; Self-Referred: 30 visits/year) ³		
Freestanding	\$40	50% after deductible
Hospital Based	\$40	50% after deductible
Occupational Therapy (Referred: 30 visits/ year; Self-Referred: 30 visits/year) ³		
Freestanding	\$40	50% after deductible
Hospital Based	\$40	50% after deductible
Speech Therapy (Referred: 20 visits/year; Self-Referred: 20 visits/year)	\$40	50% after deductible
<hr/>		
Emergency Services	Referred	Self-Referred
Emergency Room (copay not waived if admitted)	\$100	Covered at In-Network level
Emergency Ambulance	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	50% after deductible

Hospital Services	Referred	Self-Referred
Inpatient Hospital Services (Referred: 365 days/year; Self-Referred: 70 days/year) ⁴	\$250/Day; max of 5 copays per admission	50% after deductible
Observation Services	\$100	50% after deductible
Maternity Hospital Services ⁴	\$250/Day; max of 5 copays per admission	50% after deductible
Inpatient Professional Services (includes Maternity)	No charge	50% after deductible
Outpatient Surgery	Referred	Self-Referred
Freestanding	\$125	50% after deductible
Hospital Based	\$125	50% after deductible
Outpatient Professional Services	No charge	50% after deductible
Outpatient Diagnostics	Referred	Self-Referred
Diagnostic Medical (EKG)	\$40	50% after deductible
Routine Radiology (X-Ray)		
Freestanding	\$40	50% after deductible
Hospital Based	\$40	50% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	\$80	50% after deductible
Hospital Based	\$80	50% after deductible
Outpatient Lab and Pathology	Referred	Self-Referred
Freestanding	No charge	50% after deductible
Hospital Based	No charge	50% after deductible
Other Medical Services	Referred	Self-Referred
Spinal Manipulations (Referred: 20 visits/year; Self-Referred: 20 visits/year)	\$40	50% after deductible
Acupuncture (Referred: 18 visits/year; Self-Referred: 18 visits/year)	\$40	50% after deductible
Standard Injectables	No charge	50% after deductible
Allergy Injections	No charge	50% after deductible
Biotech/Specialty Injectables		
Home/Office	\$100	50% after deductible
Outpatient	\$100	50% after deductible
Chemotherapy	No charge	50% after deductible
Dialysis	No charge	50% after deductible
Skilled Nursing Facility (Referred: 60 days/year; Self-Referred: 120 days/year)	\$125/Day; max of 5 copays per admission	50% after deductible
Home Health	No charge	50% after deductible
Hospice	No charge	50% after deductible

Reference ID: HXDV05012020

Durable Medical Equipment (DME)	50%	50% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)	\$40	50% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse) ⁴	\$250/Day; max of 5 copays per admission	50% after deductible
Routine Eye Care	\$40	Not covered

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- 3 Physical Therapy, Occupational Therapy, and Cognitive Therapy combined visit limit.
- 4 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.

Keystone Point-of-Service lets you maintain freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by having care provided or referred by your primary care physician (PCP). You have the freedom to self-refer your care either to a Keystone participating provider or to providers who do not participate in our network; however, higher out-of-pocket costs apply. This program may not cover all your health care services.

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



HOSPITAL AND MEDICAL BENEFITS - PLANS NEP AND SP

The benefits described in this section are available to Active Participants, Eligible Dependents, and Retirees under the age of 65 years of age who are ineligible for Medicare (excluding those individuals who retired receiving Residential benefits under the Plan and who are not eligible for Medicare).

- NEP is for Active Participants located in Northeastern Pennsylvania.
- SP is for Sign Painters.

For information on Plan eligibility, see the section called “Eligibility and Participation.”

Personal Choice

Your hospital and medical benefits are provided through insurance policies purchased from QCC Insurance Company, a subsidiary of Independence Blue Cross (“Blue Cross”). The Plan provides a comprehensive Personal Choice program – ranging from office visits, to lab tests and X-rays, to major surgery and hospital care.

IMPORTANT: The actual insurance policy issued by QCC Insurance Company is what controls the hospital and medical benefits offered under this Plan. If there is a conflict between the contents of this Summary Plan Description (“SPD”) and the insurance policy issued by QCC Insurance Company, then the insurance policy shall control. You can contact the Fund Office if you would like to review a copy of the QCC insurance policy.

Under Personal Choice both in-network (“PPO”) and out-of-network (“non-PPO”) services are available. In-network and out-of-network services are explained in more detail later in this section. There is also a chart highlighting your main Personal Choice benefits.

Your benefits are also described in the description of benefits provided by Personal Choice. **That information (including any updates) should be considered part of, and kept with, this summary plan description (“SPD”).** The Personal Choice summary has important information, written in everyday language, on:

- **the full extent of your benefits** (including the methods used to determine whether new treatments and procedures are covered)
- **procedures to be followed to get benefits** (for example, preauthorizations, approvals, utilization reviews, out-of-area services, filing a claim for benefits, etc.)
- **limitations on benefits** – including excluded services and benefits, limits on number of visits, limits on the selection of primary care providers or providers of specialty care
- **claims review procedures** – that is, the procedures to follow if you want to appeal a claim for benefits that was denied either before or after the services were rendered (including claims for “urgent care”)
- **the circumstances in which your plan benefit could be reduced** if you have a right to sue or are entitled to reimbursement for your medical expenses from a third party
- **plan definitions**, including important terms such as “Medically Necessary”



- **privacy practices** - that is, how Personal Choice handles participants' personal health information.

If you do not have a summary of Personal Choice benefits, call the Fund Office. If you have a question that the summary does not answer, call Personal Choice at 1-800-626-8144 (outside Philadelphia) or 1-215-557-7577 (Philadelphia area). You can also get more information online at www.ibx.com.

More About In-Network and Out-of-Network Services

In-network services are services provided by doctors, hospitals, and other health care facilities/professionals that have been selected by Personal Choice to provide services to members. These providers are called “participating” providers. Some of the key features of **in-network** services include:

- The ability to choose from an extensive network of providers;
- The freedom to use a specialist without a referral;
- No deductible, coinsurance, or lifetime maximum;
- A small copay for office visits and many other services;
- No claim forms to file.

A “copay” is a fixed fee that you must pay for specific medical services covered by the Plan, such as office visits to your doctor.

Out-of-network services are services provided by a licensed provider outside of the Personal Choice network. When you select out-of-network services that are covered by the Plan:

- You are responsible for an annual deductible and coinsurance on each covered service, plus any amount above the Plan Allowance;
- You will usually have to pay the provider up front when you receive the service;
- You will need to file a claim form to be reimbursed by Personal Choice.

A “deductible” is an annual amount that you have to pay before the Plan pays any benefits. After you have met the annual deductible, the “coinsurance” is the percentage you have to pay for covered services. Under this plan the coinsurance is 30%. The “Plan Allowance” is the maximum charge Personal Choices recognizes under the Plan for a specific service, treatment or supply. You are responsible for any difference between the Plan Allowance and the actual charge.

Example: Suppose that you go to a doctor in the Personal Choice network. You pay a \$10 copay and the Plan pays the balance – there is no other cost to you.

Suppose you instead sought out-of-network care for the same problem, and the out-of-network doctor charged you \$125. However, the Plan Allowance for the service is \$50, not \$125.

Assuming that you have already met your annual out-of-network deductible of \$300, the Plan pays 70% of \$50, or \$35, and you will pay \$15 as coinsurance. You will also be responsible for the \$75 the doctor charged that exceeded the Plan Allowance, so the total amount you will be required to pay out-of-pocket for this service is \$90.



There could be substantial out-of-pocket expenses incurred by utilizing the out-of-network service.

***Finding an in-network provider.** The Fund Office will give you a copy of the Personal Choice provider directory free of charge. You can also call Personal Choice directly at 1-800-ASK-BLUE or look on their web site at www.ibx.com.*

Highlights of Your Benefits

The following table summarizes the benefits covered by your plan and shows you how much, if anything, you will be required to contribute to the cost of your medical care.



Medical Benefit Highlights

IUPAT DC #21

Covered Services	Your Costs (You pay)	
	In-Network	Out-of-Network
Benefits per Calendar Year		
Deductible (Embedded) ¹ Individual/Family	\$0/\$0	\$500/\$1,000
Out-of-Pocket Maximum (Embedded) ² Individual/Family	\$0/\$0	\$3,000/\$6,000
Coinsurance	0%	30%
Preventive Services	In-Network	Out-of-Network
Preventive Care	No charge	30% no deductible
Preventive Colonoscopy		
Preventive Plus Providers	No charge	Not covered
Hospital Based	No charge	30% no deductible
Physician Services	In-Network	Out-of-Network
Primary Care Physician (PCP) Office Visit	\$15	30% after deductible
Specialist Office Visit	\$25	30% after deductible
Retail Health Clinic Visit	\$15	30% after deductible
Telemedicine	Not covered	Not covered
Urgent Care Visit	\$28	30% after deductible
Therapy Services	In-Network	Out-of-Network
Physical Therapy (60 visits/year) ³		
Freestanding	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Hospital Based	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Occupational Therapy (60 visits/year) ³		
Freestanding	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Hospital Based	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Speech Therapy (60 visits/year) ³	Visits 1-30: \$15 Visits 31+: \$25	30% after deductible
Emergency Services	In-Network	Out-of-Network
Emergency Room (copay waived if admitted)	\$40	Covered at In-Network level
Emergency Ambulance	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	30% after deductible

Reference ID: ULOJ05012020

Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year) ⁴	\$100/Day; max of 5 copays per admission	30% after deductible
Observation Services	\$40	30% after deductible
Maternity Hospital Services ⁴	\$100/Day; max of 5 copays per admission	30% after deductible
Inpatient Professional Services (includes Maternity)	No charge	30% after deductible
Outpatient Surgery	In-Network	Out-of-Network
Freestanding	\$100	30% after deductible
Hospital Based	\$100	30% after deductible
Outpatient Professional Services	No charge	30% after deductible
Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	\$25	30% after deductible
Routine Radiology (X-Ray)		
Freestanding	\$25	30% after deductible
Hospital Based	\$25	30% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	\$25	30% after deductible
Hospital Based	\$25	30% after deductible
Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	No charge	30% after deductible
Hospital Based	No charge	30% after deductible
Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (30 visits/year) ⁵	\$25	30% after deductible
Acupuncture (18 visits/year) ⁵	\$25	30% after deductible
Standard Injectables	No charge	30% after deductible
Allergy Injections	No charge	30% after deductible
Biotech/Specialty Injectables		
Home/Office	No charge	30% after deductible
Outpatient	No charge	30% after deductible
Chemotherapy	No charge	30% after deductible
Dialysis	No charge	30% after deductible
Skilled Nursing Facility (120 days/year) ⁵	No charge	30% after deductible
Home Health	No charge	30% after deductible
Hospice	No charge	30% after deductible
Durable Medical Equipment (DME)	\$25	30% after deductible

Mental Health – Outpatient (includes serious mental illness and substance abuse)	\$25	30% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse) ⁴	\$100/Day; max of 5 copays per admission	30% after deductible

- 1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.
- 2 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.
- 3 Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Therapy combined visit limit in and out-of-network.
- 4 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.
- 5 Combined in and out-of-network.

The Personal Choice® Preferred Provider Organization (PPO) gives you freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by accessing care through Personal Choice's network of hospitals, doctors, and specialists, or by accessing care through preferred providers who participate in the BlueCard® PPO program. If you access care from a provider who does not participate in our network, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

This summary represents only a partial listing of benefits and exclusions of the Medical Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/LGBooklet or call 1-800-ASK-BLUE (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to <http://www.ibx.com/preapproval> or call the phone number that is listed on the back of your identification card.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzsch, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス(無料)をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódíílnih koji' 1-800-275-2583.

Urdu:

توجہ درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



HOSPITAL AND MEDICAL BENEFITS – PLANS T & X

The benefits described in this section are available to Active Participants, Eligible Dependents, and Retirees under the age of 65 years of age who are ineligible for Medicare through Independence Blue Cross (“IBX”). IBX benefits information is available below, as well as, through the Fund Office and the provider.

IBX Plan

**If you do not have a summary of the IBX Plan benefits,
call the Fund Office.**

**If you have a question that the summary does not answer,
call IBX at 215-557-7577.**

You can also get more information online at www.ibx.com.

Medical Benefit Highlights

IUPAT DC #21

Covered Services	Your Costs (You pay)	
	In-Network	Out-of-Network
Benefits per Calendar Year		
Deductible (Embedded) ¹ Individual/Family	\$500/\$1,500	\$1,000/\$3,000
Out-of-Pocket Maximum (Embedded) ² Individual/Family	\$2,000/\$6,000	\$4,000/\$12,000
Coinsurance	20%	40%
Preventive Services	In-Network	Out-of-Network
Preventive Care	No charge no deductible	40% no deductible
Preventive Colonoscopy		
Preventive Plus Providers	No charge no deductible	Not covered
Hospital Based	No charge no deductible	40% no deductible
Physician Services	In-Network	Out-of-Network
Primary Care Physician (PCP) Office Visit	\$35 no deductible	40% after deductible
Specialist Office Visit	\$35 no deductible	40% after deductible
Retail Health Clinic Visit	\$35 no deductible	40% after deductible
Telemedicine	Not covered	Not covered
Urgent Care Visit	\$75 no deductible	40% after deductible
Therapy Services	In-Network	Out-of-Network
Physical Therapy (90 visits/year) ³		
Freestanding	\$35 no deductible	40% after deductible
Hospital Based	Not covered	40% after deductible
Occupational Therapy (90 visits/year) ³		
Freestanding	\$35 no deductible	40% after deductible
Hospital Based	Not covered	40% after deductible
Speech Therapy (90 visits/year) ³	\$35 no deductible	40% after deductible
Emergency Services	In-Network	Out-of-Network
Emergency Room (copay waived if admitted)	\$75 no deductible	Covered at In-Network level
Emergency Ambulance	20% no deductible	Covered at In-Network level
Non-Emergency Ambulance	20% after deductible	40% after deductible

Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year) ⁴	No charge after deductible	40% after deductible
Observation Services	\$75 no deductible	40% after deductible
Maternity Hospital Services ⁴	20% after deductible	40% after deductible
Inpatient Professional Services (includes Maternity)	20% after deductible	40% after deductible
Outpatient Surgery	In-Network	Out-of-Network
Freestanding	20% after deductible	40% after deductible
Hospital Based	20% after deductible	40% after deductible
Outpatient Professional Services	20% after deductible	40% after deductible
Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	20% after deductible	40% after deductible
Routine Radiology (X-Ray)		
Freestanding	20% after deductible	40% after deductible
Hospital Based	20% after deductible	40% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	20% after deductible	40% after deductible
Hospital Based	20% after deductible	40% after deductible
Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	20% after deductible	40% after deductible
Hospital Based	20% after deductible	40% after deductible
Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (30 visits/year) ⁵	\$35 no deductible	40% after deductible
Acupuncture (18 visits/year) ⁵	\$35 no deductible	40% after deductible
Standard Injectables	20% after deductible	40% after deductible
Allergy Injections	20% after deductible	40% after deductible
Biotech/Specialty Injectables		
Home/Office	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Chemotherapy	20% after deductible	40% after deductible
Dialysis	20% after deductible	40% after deductible
Skilled Nursing Facility (100 days/year) ⁵	20% after deductible	40% after deductible
Home Health (90 visits/year) ⁵	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Durable Medical Equipment (DME)	20% after deductible	40% after deductible

Mental Health – Outpatient (includes serious mental illness and substance abuse)	\$35 no deductible	40% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse) ⁴	No charge after deductible	40% after deductible

- 1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.
- 2 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.
- 3 Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Therapy combined visit limit in and out-of-network.
- 4 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.
- 5 Combined in and out-of-network.

The Personal Choice® Preferred Provider Organization (PPO) gives you freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by accessing care through Personal Choice's network of hospitals, doctors, and specialists, or by accessing care through preferred providers who participate in the BlueCard® PPO program. If you access care from a provider who does not participate in our network, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

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Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to <http://www.ibx.com/preapproval> or call the phone number that is listed on the back of your identification card.

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Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

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Navajo: Díí baa akó nínízin: Díí saad bee yánífti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódíílnih koji' 1-800-275-2583.

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- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



HOSPITAL AND MEDICAL BENEFITS – PLANS Y & Z

The benefits described in this section are available to Active Participants, Eligible Dependents, and Retirees under the age of 65 years of age who are ineligible for Medicare through Independence Blue Cross (“IBX”). IBX benefits information is available below, as well as, through the Fund Office and the provider.

IBX Plan

**If you do not have a summary of the IBX Plan benefits,
call the Fund Office.**

**If you have a question that the summary does not answer,
call IBX at 215-557-7577.**

You can also get more information online at www.ibx.com.

Medical Benefit Highlights

IUPAT DC #21

Covered Services	Your Costs (You pay)	
	In-Network	Out-of-Network
Benefits per Calendar Year		
Deductible (Embedded) ¹ Individual/Family	\$1,200/\$3,600	\$2,400/\$7,200
Out-of-Pocket Maximum (Embedded) ² Individual/Family	\$3,000/\$9,000	\$6,000/\$18,000
Coinsurance	20%	40%
Preventive Services		
Preventive Care	No charge no deductible	40% no deductible
Preventive Colonoscopy		
Preventive Plus Providers	No charge no deductible	Not covered
Hospital Based	No charge no deductible	40% no deductible
Physician Services		
Primary Care Physician (PCP) Office Visit	\$50 no deductible	40% after deductible
Specialist Office Visit	\$50 no deductible	40% after deductible
Retail Health Clinic Visit	\$50 no deductible	40% after deductible
Telemedicine	Not covered	Not covered
Urgent Care Visit	\$100 no deductible	40% after deductible
Therapy Services		
Physical Therapy (90 visits/year) ³		
Freestanding	\$50 no deductible	40% after deductible
Hospital Based	Not covered	40% after deductible
Occupational Therapy (90 visits/year) ³		
Freestanding	\$50 no deductible	40% after deductible
Hospital Based	Not covered	40% after deductible
Speech Therapy (90 visits/year) ³	\$50 no deductible	40% after deductible
Emergency Services		
Emergency Room (copay waived if admitted)	\$100 no deductible	Covered at In-Network level
Emergency Ambulance	20% no deductible	Covered at In-Network level
Non-Emergency Ambulance	20% after deductible	40% after deductible

Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year) ⁴	No charge after deductible	40% after deductible
Observation Services	\$100 no deductible	40% after deductible
Maternity Hospital Services ⁴	20% after deductible	40% after deductible
Inpatient Professional Services (includes Maternity)	20% after deductible	40% after deductible
Outpatient Surgery	In-Network	Out-of-Network
Freestanding	20% after deductible	40% after deductible
Hospital Based	20% after deductible	40% after deductible
Outpatient Professional Services	20% after deductible	40% after deductible
Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	20% after deductible	40% after deductible
Routine Radiology (X-Ray)		
Freestanding	20% after deductible	40% after deductible
Hospital Based	20% after deductible	40% after deductible
Advanced Imaging (MRI/MRA, CT/CTA Scan, PET Scan)		
Freestanding	20% after deductible	40% after deductible
Hospital Based	20% after deductible	40% after deductible
Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	20% after deductible	40% after deductible
Hospital Based	20% after deductible	40% after deductible
Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (30 visits/year) ⁵	\$50 no deductible	40% after deductible
Acupuncture (18 visits/year) ⁵	\$50 after deductible	40% after deductible
Standard Injectables	20% after deductible	40% after deductible
Allergy Injections	20% after deductible	40% after deductible
Biotech/Specialty Injectables		
Home/Office	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Chemotherapy	20% after deductible	40% after deductible
Dialysis	20% after deductible	40% after deductible
Skilled Nursing Facility (100 days/year) ⁵	20% after deductible	40% after deductible
Home Health (90 visits/year) ⁵	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Durable Medical Equipment (DME)	20% after deductible	40% after deductible

Mental Health – Outpatient (includes serious mental illness and substance abuse)	\$50 no deductible	40% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse) ⁴	No charge after deductible	40% after deductible

- 1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.
- 2 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.
- 3 Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Therapy combined visit limit in and out-of-network.
- 4 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.
- 5 Combined in and out-of-network.

The Personal Choice® Preferred Provider Organization (PPO) gives you freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by accessing care through Personal Choice's network of hospitals, doctors, and specialists, or by accessing care through preferred providers who participate in the BlueCard® PPO program. If you access care from a provider who does not participate in our network, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

This summary represents only a partial listing of benefits and exclusions of the Medical Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/LGBooklet or call 1-800-ASK-BLUE (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to <http://www.ibx.com/preapproval> or call the phone number that is listed on the back of your identification card.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

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Important Notifications

You should be aware of certain rights provided by law.

Minimum maternity stay under the Newborns' and Mothers' Health Protection Act. The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) is a federal law that affects the length of time a mother and newborn child are covered for a hospital stay in connection with childbirth. Pursuant to federal law, the Plan shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. 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, the Plan may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Coverage Required by the Women's Health and Cancer Rights Act. Under the Women's Health and Cancer Rights Act of 1998, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. Benefits for reconstructive breast surgery following a mastectomy will be provided on the same basis, subject to applicable deductibles and coinsurance, as other surgical procedures covered by the Plan in a manner determined in consultation between the Plan, the attending physician and the patient. Such services include:

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

*If you would like more information on the reconstructive benefits, please contact the Fund Administrator by mail at 2980 Southampton- Byberry Road, Philadelphia PA 19154 or by phone at (215) 698-0978.

Mental Health Parity and Addiction Equity. Under Mental Health Parity Act of 1996 (MHPA), a group health plan offering both medical/surgical and mental health benefits generally cannot set annual or aggregate lifetime dollar limits on mental health benefits which would be lower than any such dollar limits for medical/surgical benefits. Additionally, a plan that does not impose an annual or aggregate lifetime dollar limit on medical/surgical benefits generally may not impose such a limit on mental health benefits. Lastly, a group health plan cannot place treatment limitations on mental health treatment (e.g., number of visits or days of coverage) that is more restrictive than those that apply to substantially all medical/surgical benefits.

- Increased cost exemption. MHPA does not apply to a group health plan or group health insurance if the application of the parity provisions results in an increase in the cost under the



plan or coverage of at least one percent. If the plan or insurer fall under this exemption, the plan sponsor must notify participants and beneficiaries that the MHPA does not apply to their coverage. The exemption only lasts for one-year periods as each plan that is subject to the MHPA must actively attempt to comply with the regulation yearly. A plan cannot claim an exemption before making good-faith attempts each plan year to meet the MHPA guidelines.

Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act of 2008 (MHPAEA), the protections allowed for mental health benefits through the MHPA was expanded to cover substance abuse disorders as well. As with mental health benefits, a plan that provides benefits for substance abuse in their benefit packages, cannot impose more restrictive financial requirements or treatment limitations on substance abuse disorder benefits than it does for the plan's medical/surgical benefits. The same exemptions noted for the MHPA above in this section also apply to the MHPAEA. However, if the plan or insurer fall under this exemption, the plan sponsor must notify participants and beneficiaries that the MHPAEA does not apply to their coverage. The exemption only lasts for one-year periods as each plan that is subject to the MHPAEA must actively attempt to comply with the regulation yearly. A plan cannot claim an exemption before making good-faith attempts each plan year to meet the MHPAEA guidelines.

Genetic Information Nondiscrimination. The Genetic Information Nondiscrimination Act of 2008 prohibits the Employer and the Fund from using employees' and family members' genetic information in deciding eligibility, payment of claims and contributions for group health plan benefits. In addition, the Employer and Fund cannot use genetic information for underwriting purposes.



PRESCRIPTION DRUG BENEFITS – FOR ALL ACTIVE PARTICIPANTS

The prescription drug benefit, which is administered by BeneCard PBF Member Services (“BeneCard”), provides coverage for many drugs that require a doctor’s prescription. The benefits described in this section are available **only** to Active Participants, Retirees under 65 years of age and Eligible Dependents. *The BeneCard plan of benefits is not available to Medicare-eligible Retirees and Medicare-eligible Dependents.*

How It Works

You can get prescription drugs in three different ways – from a participating pharmacy; in the case of “maintenance medications,” by mail, through BeneCard Central Fill; in the case of “specialty medications,” through BeneCard Central Fill Specialty Pharmacy.

Retail Pharmacy Benefits

When you purchase covered drugs, such as maintenance drugs, from a Participating Pharmacy, you should present your prescription order and your identification card to the pharmacist. The pharmacist will verify your benefit eligibility and determine the cost of your prescription, including your co-pay.

In the instance that you utilize a pharmacy that does not participate with BeneCard and must pay out-of-pocket for your medication, please verify that the pharmacy is not a sanctioned or excluded provider with BeneCard. If they are not sanctioned or excluded, it will be necessary for you to pay the pharmacy’s regular charge for the prescription, and then submit a Direct Member Reimbursement Form with an itemized receipt to BeneCard. The Direct Member Reimbursement Form is available at the Fund Office or online at www.benecardpbf.com. Reimbursements are based on your plan’s benefit allowance for the prescription purchased, which may be less than the retail price you paid at a Non-Participating Pharmacy.

To find a network pharmacy, you can call BeneCard at 888-907-0070 (TDD: 888-907-0020), or go to their website at www.benecardpbf.com.

Mail Order Prescriptions

This program provides you with the convenience of receiving prescription maintenance medication delivered to your home through BeneCard Central Fill. The purpose of the program is to offer maintenance drugs used for chronic conditions such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc. Your prescription can be written by your physician for to a ninety (90) day supply, plus refills. However, if you need the prescription filled right away, please use a retail pharmacy.

For your first mail order, you can ask your physician to submit the prescription electronically to BeneCard Central Fill. You can also ask your doctor to fax the prescription to [888-907-0040](tel:888-907-0040). *Please note that prescriptions sent directly from the doctor’s office can be accepted and processed via fax.*



If your doctor decides to submit your prescription via mailing, please ask them to mail the hard copy, along with a completed Mail Service Order form, to BeneCard Central Fill in the provided pre-addressed envelope. *Please make sure that your physician includes your name, ID number, date of birth and your mailing address where you want to receive your filled prescription.*

BeneCard Central Fill does not automatically refill your prescriptions. If you need a refill, please send the Refill Requires Order Form provided with your last shipment to BeneCard Central Fill mail serve in the pre-addressed envelope, along with the appropriate co-pay (if applicable). You can pay your co-pay using check, money order, credit card or debit card – do not send cash. Please allow up to two (2) weeks for delivery. Emergency prescriptions can be expedited for an additional fee.

Specialty Pharmacy

If you need to fill specialty medications, those prescriptions must be filled through the BeneCard Central Fill Specialty Pharmacy. Specialty medications are prescriptions that are high-cost biotechnology drugs which require special rules for distribution, handling and administration. Prescription fills are limited to a thirty (30) day supply.

BeneCard's clinical team will partner with you and your doctor to ensure you understand how to manage your condition and what exactly has been prescribed, how to take the medication, if there are other lower cost options available, how to safely handle/store the medication, and whether there are patient assistance programs available.

Shipment of the specialty medication will arrive in secure, temperature-controlled packaging (if necessary), and will include everything you will need to take the medication. Some mailings may require signature upon delivery.

What is Covered?

Benefits will be provided for covered drugs for out-of-hospital use and/or when prescribed by a legally licensed physician and dispensed by a legally licensed pharmacy on and after the coverage effective date. This benefit includes prescription orders which the pharmacy receives by phone from your doctor and prescription orders received by BeneCard Central Fill. Benefits are available for up to a thirty (30) day supply for specialty medications obtained through BeneCard Central Fill Specialty Pharmacy and up to a ninety (90) day supply for medications received through a retail pharmacy or from BeneCard Central Fill. ***Again, please note that BeneCard does not automatically refill prescriptions obtained by mail order.***



Copayment

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

ALL PLANS (EXCEPT T, X, Y, Z & SP)

Prescription	Retail Copayment	BeneCard Central Fill Mail Copayment	BeneCard Specialty Copayment (30-day only)
<i>Generic Prescription</i>	\$15 Copayment (30-day) \$30 Copayment (90-day)	\$30 Copayment (90-day)	\$15 Copayment
<i>Brand Name* Prescription</i>	\$25 Copayment (30-day) \$50 Copayment (90-day)	\$50 Copayment (90-day)	\$25 Copayment

PLANS T, X, Y, Z & SP

Prescription	Retail Copayment	BeneCard Central Fill Mail Copayment	BeneCard Specialty Copayment (30-day only)
<i>Generic Prescription</i>	\$20 Copayment (30-day) \$40 Copayment (90-day)	\$40 Copayment (90-day)	\$20 Copayment
<i>Brand Name* Prescription</i>	\$30 Copayment (30-day) \$60 Copayment (90-day)	\$60 Copayment (90-day)	\$30 Copayment

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



Preventative Drugs

The following drug categories are covered through your prescription benefit plan at \$0 copayment. A valid prescription from your doctor is still required in order to fill these prescriptions.

DRUG CATEGORY	AGE LIMITS
Contraceptives	≥10 years old
Aspirin for Men	45-79 years old
Aspirin for Women	55-79 years old
Folic Acid Supplement	10-55 years old
Iron Supplements for Infants	6-12 months old
Gonorrhea (Newborn Eye Drops)	0-7 days old
Fluoride Chemoprevention Supplements	6 months to 6 years old
Vitamin D Supplements	≥65 years old
Tamoxifen or Raloxifene for Breast Cancer	If clinical criteria is met

Generic Drugs

Generic equivalent drugs are required to meet the same Food and Drug Administration (FDA) standards for purity, strength, and safety as brand name drugs. These drugs are required to also have the same active ingredients and identical absorption rate within the body as the brand name version. If you wish to use a generic drug, speak with your physician about what generic drug options are available to you.

Prior Authorization

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

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

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

Step Therapy

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

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

In Step Therapy, the covered drugs you take are organized in a series of “steps,” with your



doctor approving and writing your prescriptions.

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

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

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

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

What Happens at the Pharmacy with Step Therapy

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

To receive a first-step drug:

- **Ask your pharmacist to call your doctor** and request a new prescription,
OR
- **Contact your doctor** to get a new prescription.

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

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

- **Talk with your pharmacist about filling a small supply** of your prescription right away.

You may have to pay full price for this drug. Then, ask your doctor to write you a new prescription for a first-step drug, so you are sure your medication will be covered by



our plan. Remember: Only your doctor can approve and change your prescription to a first- step drug.

To Receive a Second-Step Drug

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

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

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

Drug Quantity Management:

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

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

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

Exclusions

The following items are not covered by the Prescription Plan.

- Medications that do not require a prescription order, even if one is written, with the exception of any Preventative Care medications listed under the “Additional Benefits”;
- Medications that are not considered medically necessary;
- Medications that are considered “off-label use,” as they are not prescribed in accordance with FDA-approved utilization, or medications that are prescribed or dispensed in a manner contrary to normal medical practices;
- Medications administered by a physician or prescriber, and those not dispensed at a pharmacy, including medications you receive at your doctor's office, in a hospital, clinic, or other care facility;
- Medication for which the cost is recoverable under a government program, Workers' Compensation, occupational disease law, or medications for which no charge is made to you;
- Prescription drugs used/prescribed for cosmetic purposes;



- Prescription drugs which are labeled as experimental or for “investigative use”;
- Claims from sanctioned or excluded providers;
- Immunologicals, vaccines, allergy sera, biological sera, blood plasma, and charges for the administration or injection of medications;
- Hair loss medications;
- Weight control;
- Infertility treatments;
- Erectile dysfunction drugs are covered with restrictions.

Please not that this list may not include all exclusions and is subject to change. For more information on your Prescription Plan coverage, please visit www.benecardpbf.com.

Filing a Claim

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



DENTAL BENEFITS – “A” PLAN – PLANS A, E, F, NEP, RES, SP, T, X, Y and Z

Fidelio Dental Insurance Company “Fidelio” (2826 Mount Carmel Avenue, Glenside, PA 19038 Tel: 215-885-2443 or 1-800-262-4949, www.fideliodental.com) administers the A Plan on behalf of the Fund on a self-insured basis for Plans A, E, F, NEP, RES, SP, T, X Y and Z.

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

PLEASE NOTE: Maximum annual benefit for those Active Participants, Eligible Dependents and Retirees covered by the A Plan for the contract year is \$1,500 per participant.

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

Covered Benefits

The dental benefit covers the following types of services:

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



- **Night Guards (Bite Appliances)** – The Plan will allow coverage once every three years with a co-pay of 50% by the patient.
- **Adult Ortho** – The Plan will cover on a 100% of the UCR up to a \$1,000 lifetime maximum for in-network providers. For out-of-network providers, 50% of the UCR up to a lifetime limit of \$500.
- **Dental Implants** – Subject to plan coverage limits regarding in-network or out-of-network dental providers, coverage for dental implants shall include all three components of the dental implant procedure – the implant body, abutment, and implant crown – together with related services, included any necessary bone or tissue grafting.

How It Works

How the dental benefit works depends on the following:

- When you go to a **participating** dentist, the Plan pays a percentage of the dentist's charge, as shown on the schedule of benefits. Fidelio shall advise you of any charges that it will not cover and for which you are responsible.
- When you go to a **non-participating** dentist, the Plan pays a percentage of the Usual, Customary and Reasonable Allowance ("UCR") established by Fidelio. The UCR is the maximum amount Fidelio recognizes for a particular service. You will be responsible for the remaining percentage, in addition to any amount above the UCR that is not covered.

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

Predetermination Review Estimates

Predetermination review is mandatory if the prescribed course of treatment is expected to cost \$300 or more. Predetermination is always mandatory prior to receipt of Invisalign treatment or Dental Implants from your dentist. This review will provide your dentist with proof of your eligibility and benefit availability under the Plan. This review also makes you aware of what your out-of-pocket expenses will be before you begin the dental procedure.

In order to receive the predetermination review estimate, you and your dentist must submit a pretreatment review form to Fidelio. After Fidelio reviews the information provided by the form, both you and your dentist will receive the predetermination voucher estimate.



Schedule of Dental Benefits

The A Plan covers the services listed in the following schedule up to an annual maximum of \$1,500 per person. The lifetime limit for Invisalign Clear Aligners and Dental Implants is separate from, and will not be counted against, your annual maximum.

DENTAL BENEFITS		
Covered Services	Fidelio Pays This Percentage of UCR:	You Pay This Percentage of UCR: (plus any amount in excess of UCR charged by a non-participating dentist)
Crown and Bridge	90%	10%
Preventive	100%	0%
Diagnostic	100%	0%
Basic Restorative	100%	0%
Oral Surgery	90%	10%
Endodontics	90%	10%
Periodontics	90%	10%
Dentures (full or partial)	70%	30%
Orthodontics (Adolescent Only) <u>In-Network (Braces & Invisalign)</u>	100% of Fidelio UCR up to \$4,000	Any remaining amount due that exceeds the \$4,000 limit
Orthodontics (Adolescent Only) <u>Out-of-Network (Braces & Invisalign)</u>	50% of Fidelio UCR up to \$2,000	The other 50% of the UCR and any remaining amount due that exceeds the \$2,000 limit
Orthodontics (Age 19 and Up) <u>In-Network (Braces & Invisalign)</u>	100% of the Fidelio UCR up to \$1,000	Any remaining amount due that exceeds the \$1,000 limit
Orthodontics (Age 19 and Up) <u>Out-of-Network (Braces & Invisalign)</u>	50% of Fidelio UCR up to \$500	The other 50% of the UCR and any remaining amount due that exceeds the \$500 limit
Dental Implants (Actives and their Dependents) <u>In-Network</u>	80% of Fidelio UCR subject to lifetime limit, per person \$12,000 All Dental Implants	The other 20% of the UCR, and any amount, in total, exceeding \$12,000
Dental Implants (Actives and their Dependents) <u>Out-of-Network</u>	40% of Fidelio UCR subject to lifetime limit, per person \$6,000 All Dental Implants	The other 60% of the UCR, and any amount, in total, exceeding \$6,000



What is Not Covered

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

- Treatment or materials which are benefits under Medicare or Medicaid unless this exclusion is prohibited by law.
- Treatment or material with respect to congenital skeletal malformation or treatment of enamel hypoplasia (lack of development), except that this exclusion shall not affect eligible newborn children as described in the definition of Dependent so long as such dependent children continue to be eligible. When services are not excluded under this provision as to dependent children who continue to be eligible, other limitations and exclusions of this Section shall specifically apply.
- Treatment that increases the vertical dimension of an occlusion, replace tooth structure lost by attrition or erosion, or otherwise unless it is part of a treatment dentally necessary due to accident or injury and directly attributable thereto.
- Treatment or materials primarily for cosmetic purposes including but not limited to treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a treatment dentally necessary due to accident or injury and directly attributable thereto. If services are not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent or near the affected ones is excluded.
- Treatment or materials in which the member would have no legal obligation to pay.
- Services provided or material furnished prior to your effective eligibility date unless this treatment was a year in duration and was completed after you became eligible except insofar as the limitations of this Section do not apply.
- Periodontal splitting, equilibration, gnathological recording and associated treatment, and extra-oral grafts.
- Preventive plaque control programs, including oral hygiene instruction programs.
- Myofunctional therapy.
- Temporomandibular joint dysfunction.
- Prescription Drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia.
- Experimental procedures which have not been accepted by the American Dental Association.
- Services provided or material furnished after the termination date of coverage.
- Treatment or materials provided in a hospital or any other surgical treatment facility.
- Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- Replacement of existing restoration for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.



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

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

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

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

Limitation on Prophylaxis, Fluoride and Sealants. Prophylaxes and fluoride application may be performed either together or separately. Prophylaxes are limited to once in any six-month period. Fluoride applications as a benefit are limited to once in any six-month period up to age 19. Sealants are limited up to age 14, once in any 36 months on unfilled permanent first and second molars.

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

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



Limitation on Periodontal Surgery. Benefits for periodontal surgery in the same quadrant are limited to once in any five-year period. The five-year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this plan, under any prior dental contract by which you were covered or paid for directly by you.

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

Limitation on Composite Fillings. Treatment to restore carious lesions is limited to synthetic porcelain and plastic materials. Replacement of composite fillings on permanent posterior teeth shall be provided no more often than once in any 24-month period. The 24-month period shall be measured from the date on which the restoration was last supplied, whether paid for under this Plan, under any prior dental care agreement by which you were covered or paid for directly by you.

Prohibition against Receipt of both Invisalign and Traditional Braces. Each eligible participant or dependent covered by your Plan is allowed to receive benefits for either Invisalign Clear Aligners or Traditional Orthodontic Braces – **but cannot receive benefits for both.** The Plan will only pay for one of these orthodontic treatments on behalf of each eligible participant or dependent.

Filing a Claim

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



DENTAL BENEFITS – “B” PLAN – PLANS B, G, N, HA, AP, and L

Fidelio Dental Insurance Company “Fidelio” (2826 Mount Carmel Avenue, Glenside, PA 19038 Tel: 215-885-2443 or 1-800-262-4949, www.fideliodental.com) administers the B Plan on behalf of the Fund on a self-insured basis for Plans B, G, N, HA, AP, and L.

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

PLEASE NOTE: Maximum annual benefit for those Active Participants, Eligible Dependents and Retirees covered by the B Plan for the contract year is \$1,500 per participant.

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

Covered Benefits

The dental benefit covers the following types of services:

- **Diagnostic Care** – Procedures to assist dentists to evaluate existing conditions and dental care required – this includes visits, exams, diagnoses and x-rays (exams and bitewing x-rays once in any six-month period).
- **Preventive Care** – Prophylaxis (cleaning once in any six-month period), fluoride treatments (limited to under age 19), space maintainers, sealants (to under age 14, once in any 36 months on unfilled permanent first and second molars).
- **Basic Restorative Services** – Amalgam and composite fillings.
- **Crown and Bridge Services** – Crowns, bridges, inlays and onlays are covered when other services are not adequate.
- **Oral Surgery** – Extractions and oral surgery procedures including pre- and post-operative care.
- **Endodontics** – Procedures for pulpal therapy and root canal filling.
- **Periodontics** – Surgical and non-surgical procedures for treatment of gums and supporting structures of teeth.
- **Dentures** – Procedures for construction or repair of partial or full dentures.
- **Orthodontics** - Procedures for straightening teeth.
- **Bleaching (Teeth Whitening)** – The Plan allows up to \$300 per year with a co-pay of



50% by the patient for in-home treatment. In addition, the Plan will allow \$500 for one treatment per year with a co-pay of 50% by the patient for an in-office treatment.

- **Night Guards (Bite Appliances)** – The Plan will allow coverage once every three years with a co-pay of 50% by the patient.
- **Adult Ortho** – The Plan will cover on a 100% of the UCR up to a \$1,000 lifetime maximum for in-network providers. For out-of-network providers, 50% of the UCR up to a lifetime limit of \$500.

How It Works

How the dental benefit works depends on the following:

- When you go to a **participating** dentist, the Plan pays a percentage of the dentist's charge, as shown on the schedule of benefits. Fidelio shall advise you of any charges that it will not cover and for which you are responsible.
- When you go to a **non-participating** dentist, the Plan pays a percentage of the Usual, Customary and Reasonable Allowance ("UCR") established by Fidelio. The UCR is the maximum amount Fidelio recognizes for a particular service. You will be responsible for the remaining percentage, in addition to any amount above the UCR that is not covered.

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

Predetermination Review Estimates

Predetermination review is mandatory if the prescribed course of treatment is expected to cost \$300 or more. Predetermination is always mandatory prior to Invisalign treatment from your dentist. This review will provide your dentist with proof of your eligibility and benefit availability under the Plan. This review also makes you aware of what your out-of-pocket expenses will be before you begin the dental procedure.

In order to receive the predetermination review estimate, you and your dentist must submit a pretreatment review form to Fidelio. After Fidelio reviews the information provided by the form, both you and your dentist will receive the predetermination voucher estimate.



Schedule of Dental Benefits

The B Plan covers the services listed in the following schedule up to an annual maximum of \$1,500 per person. The lifetime limit for Invisalign Clear Aligners is separate from, and will not be counted against, the annual maximum.

DENTAL BENEFITS		
Covered Services	Fidelio Pays This Percentage of UCR:	You Pay This Percentage of UCR: (plus any amount in excess of UCR charged by a non-participating dentist)
Crown and Bridge	70%	30%
Preventive	100%	0%
Diagnostic	100%	0%
Basic Restorative	100%	0%
Oral Surgery	70%	30%
Endodontics	70%	30%
Periodontics	70%	30%
Dentures (full or partial)	50%	50%
Orthodontics (Adolescent Only) <u>In-Network (Braces & Invisalign)</u>	100% of Fidelio UCR up to \$4,000	Any remaining amount due that exceeds the \$4,000 limit
Orthodontics (Adolescent Only) <u>Out-of-Network (Braces & Invisalign)</u>	50% of Fidelio UCR up to \$2,000	The other 50% of the UCR and any remaining amount due that exceeds the \$2,000 limit
Orthodontics (Age 19 and Up) <u>In-Network (Braces & Invisalign)</u>	100% of the Fidelio UCR up to \$1,000	Any remaining amount due that exceeds the \$1,000 limit
Orthodontics (Age 19 and Up) <u>Out-of-Network (Braces & Invisalign)</u>	50% of Fidelio UCR up to \$500	The other 50% of the UCR and any remaining amount due that exceeds the \$500 limit
Dental Implants (Actives and their Dependents) In-Network	80% of Fidelio UCR subject to lifetime limit, per person \$12,000 All Dental Implants	The other 20% of the UCR and any amount in total, exceeding \$12,000
Dental Implants (Actives and their Dependents) Out-of-Network	40% of Fidelio UCR subject to lifetime limit, per person \$6,000 All Dental Implants	The other 60% of the UCR and any amount in total, exceeding \$6,000



What is Not Covered

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

- Treatment or materials which are benefits under Medicare or Medicaid unless this exclusion is prohibited by law.
- Treatment or material with respect to congenital skeletal malformation or treatment of enamel hypoplasia (lack of development), except that this exclusion shall not affect eligible newborn children as described in the definition of Dependent so long as such dependent children continue to be eligible. When services are not excluded under this provision as to dependent children who continue to be eligible, other limitations and exclusions of this Section shall specifically apply.
- Treatment that increases the vertical dimension of an occlusion, replace tooth structure lost by attrition or erosion, or otherwise unless it is part of a treatment dentally necessary due to accident or injury and directly attributable thereto.
- Treatment or materials primarily for cosmetic purposes including but not limited to treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a treatment dentally necessary due to accident or injury and directly attributable thereto. If services are not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent or near the affected ones is excluded.
- Treatment or materials in which the member would have no legal obligation to pay.
- Services provided or material furnished prior to your effective eligibility date unless this treatment was a year in duration and was completed after you became eligible except insofar as the limitations of this Section do not apply.
- Periodontal splitting, equilibration, gnathological recording and associated treatment, and extra-oral grafts.
- Preventive plaque control programs, including oral hygiene instruction programs.
- Myofunctional therapy.
- Temporomandibular joint dysfunction.
- Prescription Drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia.
- Experimental procedures which have not been accepted by the American Dental Association.
- Services provided or material furnished after the termination date of coverage.
- Treatment or materials provided in a hospital or any other surgical treatment facility.
- Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- Replacement of existing restoration for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.



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

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

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

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

Limitation on Prophylaxis, Fluoride and Sealants. Prophylaxes and fluoride application may be performed either together or separately. Prophylaxes are limited to once in any six-month period. Fluoride applications as a benefit are limited to once in any six-month period up to age 19. Sealants are limited up to age 14, once in any 36 months on unfilled permanent first and second molars.

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

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



Limitation on Periodontal Surgery. Benefits for periodontal surgery in the same quadrant are limited to once in any five-year period. The five-year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this plan, under any prior dental contract by which you were covered or paid for directly by you.

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

Limitation on Composite Fillings. Treatment to restore carious lesions is limited to synthetic porcelain and plastic materials. Replacement of composite fillings on permanent posterior teeth shall be provided no more often than once in any 24-month period. The 24-month period shall be measured from the date on which the restoration was last supplied, whether paid for under this Plan, under any prior dental care agreement by which you were covered or paid for directly by you.

Prohibition against Receipt of both Invisalign and Traditional Braces. Each eligible participant or dependent covered by your Plan is allowed to receive benefits for either Invisalign Clear Aligners or Traditional Orthodontic Braces – **but cannot receive benefits for both.** The Plan will only pay for **one** of these orthodontic treatments on behalf of each eligible participant or dependent.

Filing a Claim

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



VISION BENEFITS – FOR ALL PLANS (ACTIVES AND RETIREES)

National Vision Administrators, Inc. (“NVA”) (1200 Route 46 West, Clifton, New Jersey 07013, Tel: 1-800-672-7723; TDD Line: 888-820-2290, www.e-nva.com), administers the program on behalf of the Fund on a self-insured basis. The benefits described in this section are available to Active Participants, Eligible Dependents, and Retirees.

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

In-network providers: You may select from a panel of qualified ophthalmologists and optometrists by visiting the NVA website or calling customer care. When visiting a participating NVA provider, if you are an eligible participant under nineteen (19) years of age, you are entitled to receive under this Plan, an examination and lenses (including single, bifocal, trifocal, oversized or lenticular lenses – whether they are standard glass or plastic), which will be covered in full, every twelve (12) months for participants. Those participants under the age of nineteen (19) are also entitled to receive either one (1) pair of contact lenses once every twelve (12) months or a frame once every twenty-four (24) months from last date of service. However, if you choose a frame, you will be ineligible for contact lenses for a twenty-four (24) month period.

For eligible participants nineteen (19) years of age and older, you are entitled to receive an examination, and a frame or contact lenses once every twenty-four (24) months from the last date of service. If you choose a frame, you will be ineligible for contact lenses for a twenty-four (24) month period.

In addition, the Plan provides a up to a \$100.00 wholesale cost allowance for frames every twenty-four (24) months. The \$100.00 wholesale cost allowance is equivalent to approximately \$90 in retail dollars. Also, the participating NVA provider is only allowed to charge the wholesale cost plus 20% for frames with a wholesale allowance greater than the Plan allowance of \$100.00. In addition, lens options will be available at the wholesale cost plus 25%:

In lieu of glasses, contact lenses (if they are elective, and not medically necessary) will be covered up to \$75 of the retail price, excluding the examination fee. Participating NVA providers will charge their usual, customary, and reasonable fee less 25%. If the contact lenses are medically necessary**, NVA will cover 100% of the cost but you must obtain prior authorization first.

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

To File a Claim After Visiting Out-of-network/Non-participating Providers – You are responsible for the full cost of services and supplies at the time of service from the non-participating, out-of-network provider. The Plan will reimburse you, for such services noted



below on the schedule of benefits, for up to the specified amounts shown. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts, along with a letter containing the member's full name, patient's full name (if patient was someone other than the member), address, identification number, and the sponsoring organization (here IUPAT DC21 Benefit Funds) to NVA, P.O. Box 2187, Clifton, NJ 07015.

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

Out-of-Network Vision Benefit	Out-of-Network Allowance (The Fund will reimburse you for the following amounts.)
Examination	Up to \$30
Single Vision Lenses (pair)	Up to \$24
Bifocal Vision Lenses (pair)	Up to \$36
Trifocal Vision Lenses (pair)	Up to \$46
Lenticular Vision Lenses (pair)	Up to \$72
Frames	Up to \$25
Cosmetic/Elective Contact Lenses (instead of frames)	Up to \$18
Contact Lenses -if "medically necessary"** (instead of frames/not for cosmetic purposes)	Up to \$45

**"Medically necessary" means that the contact lenses that are prescribed for any of the following conditions:

- post-cataract surgery,
- to correct extreme visual acuity problems that cannot be corrected to 20/70 with glasses,
- to assist with correction of Anisometropia, or
- to assist with the treatment of Keratoconus.
 - "Medically necessary" contact lenses includes fitting and follow-up, and may be covered with receipt of prior authorization.



Covered Services

- Eligible Dependents under age 19: entitled to receive an eye exam and one (1) pair of lenses once every 12 months and a frame once every 24 months from last date of service, or and contact lenses once every 12 months from last date of service.
- Eligible members and dependents age 19 and older: entitled to receive an eye exam and glasses (lenses and frame) or contact lenses once every 24 months from last date of service.
 - If you chose a frame, you are not eligible for contact lenses for a period of 24 months.

Eye examinations include, but are not limited to:

- Case history (Generally, Chief Complaint, Medications, Personal History and Family History)
- Examination for pathology or anomalies (internal and external)
- Test of Pupillary Function
- Occupational vision analysis
- Refraction
- Coordination test measurements
- Near point visual functions analysis
- Visual field charting (when necessary)
- Dilation (if professionally indicated)
- Tonometry (glaucoma test), and
- Case analysis and disposition.

What's Not Covered

The Plan does not cover the following:

- Medical treatment of the eye
- Prescription drugs or over-the-counter medications
- Non-prescription lenses
- Two pair of glasses in lieu of bifocals
- Subnormal visual aids
- Examination or materials required for employment
- Replacement of lost, stolen, broken or damaged lenses



- Contact lenses or frames except at normal intervals when service is otherwise available
- Services or materials provided by federal, state, local government or Workers' Compensation
- Examination, procedures' training or materials not listed as a covered service
- Industrial (3 mm) safety lenses and safety frames with (or without) side shields
- Sunglasses
- Parts or repair of frames.

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

Additional benefits

In addition to your other vision benefits outlined in this Section, the Fund provides a LASIK benefit to all Participants of the Plan. The Fund shall reimburse Participants who elect to obtain LASIK surgery \$1000 per eye for up to \$2000 maximum. Participants can obtain the surgery from a provider of their choosing. To obtain the benefit, the Participant must pay for the entire procedure out-of-pocket, then provide proof of the procedure and their payment to the Fund Office for reimbursement.

This is a one-time benefit that applies to all benefit plans – Active, Retiree and Residential. Please be advised that the Fund shall not reimburse a participant for additional LASIK procedures obtained if a reimbursement request was previously submitted by the Participant and paid by the Fund.

There may be discounts available for mail order contact lenses through Contact Fill. Find out more on the Contact Fill website www.contactfill.com.

Furthermore, you may be eligible to access the EyeEssential Plan discount for use on additional purchases made only through Participating Providers during the plan period. Please note that the discount for contact lenses can only be used for in-store purchases with Participating Providers. See table below for more information.....

Your NVA EyeEssential Plan Discount – In-Network Only

Service	Participating Provider	Lens Options
Eye Examination:	<u>Member Cost:</u>	\$12 Solid Tint/Gradient Tint
Contact Lens Fitting:	<u>Retail Less \$10</u>	\$50 Standard Progressive Lenses
Lenses:	<u>Retail Less 10%</u>	\$75 Polarized Lenses
• Single Vision	Glass or Plastic	\$65 Transitions Single Vision Standard
• Bifocal	• \$35.00	\$70 Transitions Multi-Focal Standard
• Trifocal or Lenticular	• \$55.00	\$15 Standard Scratch Coating
	• \$70.00	\$12 UV Coating
		\$35 Polycarbonate
		\$45 Standard Anti-Reflective



Frame: Retail Less 35%

Contact Lenses:*

Conventional Retail Less 15%

Disposable Retail Less 10%

*Discounts for contact lenses does not apply to those ordered via mail. Please see note about ordering contact lenses by mail through Contact Fill.



WEEKLY DISABILITY BENEFIT

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

Eligibility Requirements

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

What the Benefit is

You are entitled to receive a weekly benefit of \$350 and 27 credit hours towards your health coverage.*

*In the instance that your disability is due to attendance of a rehabilitation center for substance abuse, you are permitted one lifetime claim for the weekly disability benefit.

Definition of “Disability”

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

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

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

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

When Payments Start and End

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

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



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

If you have successive periods of disability. If you have two or more periods of disability that are separated by less than ten (10) days of continuous employment or are due to related causes or related sources of injury/illness, then such periods are considered one period of disability, and will count toward the same maximum 26-week period of disability payments.

Please note: When your temporary disability recurs, even if a significant period of time has passed since you were last out of work for the same or related disability, the 26-week benefit period does not restart. Instead, the benefit period continues from where you left off. Below are some examples to illustrate the rules relating to the continuance of the 26-week benefit period:

Example 1: Employee A received Weekly Disability Benefits for a period of five (5) weeks related to treatment for substance abuse. Employee A then returns to work for a year. After a year, Employee A suffers a relapse and needs further substance abuse treatment. Employee A applies again for Weekly Disability Benefits; however, because Employee A applied for a disability that is related to his/her previous cause or source of disability, Employee A's benefits would restart at Week 6 of the 26-week benefit period.

Example 2: Employee B received Weekly Disability Benefits for a period of six (6) weeks for a broken leg incurred during a skiing accident. After healing from the leg injury, Employee B returns to work for two (2) years. Employee B then breaks the same leg falling off a ladder at home and applies for Weekly Disability Benefits. Because the second cause of the injury for his/her broken leg differs from the first cause (falling off the ladder vs. injury during sport), Employee B is entitled to receive benefits for a new benefit period of 26 weeks.

Example 3: Employee C has cancer and received nine (9) weeks of Weekly Disability Benefits in order to undergo chemotherapy. Employee C is then cleared to return to work. After a period of five (5) years, Employee C is diagnosed with a different form of cancer. Employee C applies again for Weekly Disability Benefits in order to undergo radiation therapy. Employee C is entitled to receive a new benefit period of 26 weeks for his/her disability because this source (or cause) of disability is a different form of cancer.

Filing a Claim

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

If you have previously applied, and received Weekly Disability Benefits, and you believe that your current disability **does not relate to the previous disability for which you had received benefits**, please explain these circumstances to the Fund in when completing your application for



Weekly Disability Benefits. The Fund shall review this information in its consideration of your application and provide you with its determination.

Exclusions

Benefits cannot be paid if:

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

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



LIFE INSURANCE

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

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

If you die while covered by the Fund, your designated beneficiary will receive a \$50,000 life insurance benefit.

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

Your Beneficiary

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

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

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

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

Continuation of Coverage During Disability

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



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

Required notice

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

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

Converting to an Individual Policy

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

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

Accelerated Benefit

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

Filing a Claim

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

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



ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

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

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

Death Benefit

In addition to the receipt of the life insurance benefit noted above in the previous section, your designated beneficiary may be eligible to receive an additional benefit payout of \$50,000 should you die as a result of an accident.

Whether your death is accidental, and therefore eligible for the payout of this additional benefit, shall be subject to a review and determination by the insurance carrier – not the Fund or Benefit Office. Your beneficiary must submit a certified copy of your death certificate and request the death benefit in writing within one year of the date of your death.

Dismemberment Benefits

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

Schedule of Benefits

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

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



Your Beneficiary

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

Exclusions

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

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

How to File a Claim

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

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



RETIREE BENEFITS

The Plan also provides benefits for eligible Retirees and their Eligible Dependents. (For information on Plan eligibility, see the section called “Eligibility and Participation.”) ***In order to be eligible for this coverage, you must timely pay your union dues to IUPAT DC21.*** Retiree hospital and medical benefits are provided through insurance policies purchased from either Blue Cross, with the exception of those retirees covered by Plan L, whose hospital and medical benefits are provided through insurance policies purchased through Keystone POS. ***For any questions related to changes in coverage, contact the Fund Office at 800-252-7252 or 215-934-5130.***

IMPORTANT: With the exception of Plan L Retirees, whose insurance policy is under Keystone POS, the actual insurance policies for all other Plan retirees are issued Independence Blue Cross. The insurance policy that governs your respective plan of benefits controls the retiree hospital and medical benefits that you are offered under this Plan. If there is a conflict between the contents of this SPD and the insurance policies, then the insurance policies shall control. You can contact the Fund Office if you would like to review a copy of the insurance policies.

- **If you are eligible for Medicare and you meet the requirements for Retiree coverage**, the Fund offers Medicare Supplement coverage. Upon retirement, you will receive six (6) months of free Supplement coverage for the first six (6) months of your retirement. Thereafter, once the sixth (6th) month ends, you will be required to pay for this coverage. For more information on Medicare and the Plan’s coverage, see the following sections.
- **If you are not eligible for Medicare and you meet all of the Plan’s requirements for Retiree coverage**, you will receive six (6) months of free coverage. Thereafter, once the sixth (6th) month ends, you will be required to pay for this coverage. The Plan will continue to provide you with medical, prescription drug, dental, and vision benefits. However, you will be required to pay for this coverage. For more information, see the section called “Retirees Who Are Not Eligible for Medicare.”

More About Medicare – PLEASE NOTE: IN ORDER TO PARTICIPATE IN THIS PLAN, YOU MUST HAVE BOTH PARTS A AND B

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

Medicare provides benefits as follows:

- **Part A** – provides inpatient hospital services, post-hospital extended care services, home health services and hospice care.
- **Part B** – provides doctors’ services, outpatient hospital and a number of other health care services.

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



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

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

When You are Eligible for Medicare

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

Medicare Supplement Plan

MEDICARE (PART A) - HOSPITAL SERVICES- PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days Once lifetime reserve days are used: -Additional 365 days - Beyond the Additional 365 days	All but \$1484 All but \$371 a day All but \$742 a day \$0 \$0	\$1484 (Part A Deductible) \$371 a day \$742 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$185.50 a day \$0	\$0 Up to \$185.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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



MEDICARE (PART B) - MEDICAL SERVICES- PER BENEFIT PERIOD

* Once you have been billed \$203 of Medicare-approved amounts for covered services (which are noted with an asterisk below), Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	100% of the amount not paid by Medicare	\$0 \$0 \$0
BLOOD First 3 pints Next \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs 100% of the amount not paid by Medicare	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES- TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 100% of the amount not paid by Medicare	\$0 \$0 \$0
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OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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Additional benefits. In addition to the medical benefits provided, the Plan also provides you with prescription drug, dental, and vision care benefits. Some information concerning Medicare-Part D can be found below; however, for additional information about your prescription benefit coverage, please review the “Prescription Drug Benefit” section. For a description of the dental and vision benefits, please see the designated sections that describe these benefits.



MEDICARE (PART D) –RETIREE PRESCRIPTION DRUG PLAN EXPRESS SCRIPTS (PDP)

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service.

You do not pay a yearly deductible				
You will pay the following until your total yearly drug costs (what you and the plan pay) reach \$4,430:				
Tier	Retail One Month (31-day) Supply	Retail Two Month (32-60-day) Supply	Retail Three Month (90-day) Supply	Home Delivery Three Month (90- day) Supply
Tier 1: Preferred Generic	\$15 Copayment	\$30 Copayment	\$30 Copayment	\$30 Copayment
Tier 2: Generic Drug	\$15 Copayment	\$30 Copayment	\$30 Copayment	\$30 Copayment
Tier 3: Preferred Brand Drugs	\$25 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment
Tier 4: Non-Preferred Drugs	\$25 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment
Tier 5: Specialty Tier Drugs	\$25 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment



If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.

*Your cost-sharing amount may differ from the information shown in this chart if you use a home delivery pharmacy other than Express Scripts Pharmacy. Other pharmacies are available in our network.

You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through the Express Scripts Pharmacysm. There is no charge for standard shipping. Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.

If you have any questions about this coverage, please contact the Retiree Customer Service Center 1.800.236.4782 Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.



IMPORTANT PRESCRIPTION PLAN INFORMATION

Long-Term Care (LTC) Pharmacy

If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one-month supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage

You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact the plan or the Retiree Customer Service Center for more details.

Additional Information About This Coverage

- The service area for this plan is all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this plan.
- The amount you pay may differ depending on what type of pharmacy you use; for example, retail, home infusion, LTC or home delivery.
- To find a network pharmacy near you, visit **www.express-scripts.com**.
- Your plan uses a formulary – a list of covered drugs. The amount you pay depends on the drug's tier and on the coverage stage that you've reached. From time to time, a drug may move to a different tier. If a drug you are taking is going to move to a higher (or more expensive) tier, or if the change limits your ability to fill a prescription, Express Scripts will notify you before the change is made.
- To access your plan's list of covered drugs, visit **www.express-scripts.com**.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Please see the "Step Therapy" Description that can be found in the "Prescription Drug Benefit" Section of this document.
- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
- Each month, you may need to pay a monthly premium amount to continue your participation in this plan. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party, even if your Medicare Part D plan premium is \$0.



Additional Retiree Benefits Information

Retirees Who Are Not Eligible for Medicare. If you retire before becoming eligible for Medicare, you are eligible for continued medical, prescription drug, dental and vision coverage, so long as you remit your required payments. For Retirees who were covered under Plans T, X, Y & Z as an Active Member, you are eligible to continue your coverage under Plan T&X. For Retirees who were covered under Plan L as an Active Member, you are eligible to continue coverage under the same plan of benefits. For all other Retirees, you are eligible to continue your coverage under the Plan B plan of benefits. For descriptions of these benefits, please refer to the appropriate sections found above in this SPD.

When you must begin to pay for coverage. When you retire, your coverage will continue free of charge for six months. At the end of your free extended coverage period, you must make the required payments to continue coverage for yourself and your dependent(s) **in the preceding month to receive coverage for the following month. It's your responsibility to make the payments on time. If you do not pay timely, you will receive a notice that your coverage has been terminated by the Plan.**

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

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

Dependent Coverage

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

Payment for Retiree Coverage

When you retire, the Fund will notify you when your initial self-payment is due, thereafter you are responsible for making payment to the Fund timely and shall not receive a subsequent notice of when payment is due to the Fund.

Should the Fund's Board of Trustees change the rate, you shall receive notice of that change.



How to Claim Benefits

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

Continuation of Benefits

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

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

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

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



COORDINATION OF BENEFITS

Our Plan has a coordination of benefits (COB) provision. This provision ensures that if you or an Eligible Dependent is covered by another group medical plan, benefits from all plans combined will not exceed 100% of the maximum allowable expense provided for under this plan. **Please note that the Plan's providers may also have COB provisions that may impact expenses covered by the Plan, please contact the appropriate provider for assistance.**

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

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

Which Plan Pays First

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

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

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



benefits (Part A) and supplemental medical benefits (Part B) under Medicare. If you are a retiree, Medicare is the primary plan, and this plan is secondary. Otherwise, if you are 65 or older and continue to work, this plan is primary and Medicare is secondary.

Medicare and End-Stage Renal Disease (ESRD): ESRD is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. A person may become entitled to Medicare based on this disease. If you are eligible for Medicare on the basis of ESRD, the plan is your primary coverage for hospital and medical bills for the first thirty (30) months, regardless of whether you are enrolled in Medicare. During this first thirty (30) month period, if you are enrolled in Medicare, your coverage under Medicare is secondary to the plan's primary coverage. However, at the end of the thirty (30) month period, your Medicare coverage will become primary.

If you have elected benefits through COBRA but are also eligible for Medicare based on your ESRD, your COBRA continuation coverage will be your primary coverage and pay first to the extent that the COBRA coverage overlaps the first thirty (30) months of Medicare eligibility or entitlement based on your ESRD.

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

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

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

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



- If **you** (as a Plan participant) have incurred medical expenses, you should first file a claim with this Plan. Once this claim has been settled, if there are any unreimbursed amounts (such as deductibles or copays), you may then file a claim with your spouse's plan, including a copy of the original claim and the explanation of benefits. The unreimbursed amount will then be considered for reimbursement subject to the provisions of your spouse's plan.

Lastly, in no event will the amount paid from this Plan, when combined with the amount paid from any other insurance, exceed 100% of the Plan's benefit. Similarly, if this Plan is secondary or considered excess insurance, for example in the instance where a third party is liable for the claims of you (or your beneficiary), then its liability is further limited to the lesser of the participant's liability or what the primary plan paid on the claim.



BENEFIT CLAIM DETERMINATIONS AND APPEALS

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

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

Claims for Benefits Paid by Insurance Carriers

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

Urgent Care Claims

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

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

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

Claims Involving Concurrent Care/Ongoing Treatment

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



such reduction or termination will be considered a claim denial (except when a Plan amendment or termination causes the reduction or termination of the treatment or care).

You may request that a course of treatment be extended beyond the approved time period or number of treatments. If your request is for a course of treatment that does not involve urgent care, the request will be treated as a new benefit claim and therefore decided within the timeframe appropriate for the type of claim, i.e., as a pre-service claim or a post-service claim. However, if your concurrent care claim involves a request to extend treatment for urgent care, you will be notified of the Plan's decision (adverse or not) as soon as possible but no later than 24 hours prior to the expiration of the treatment period or number of treatments (provided your claim is submitted to the Plans no later than 24 hours prior to the expiration of the prescribed period of time or number of treatments).

Pre-Service Claims

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

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

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

Post-Service Claims

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



A one-time extension of up to 15 days is allowable for matters beyond the control of the Plan, such as insufficient information submitted with your claim. You will be notified of any additional extension, including the reason why the extension is necessary, a description of any information necessary to complete your claim, and the date by which the Plan expects to make a decision, within 30 days from the date the claim was originally filed. If the extension is due to insufficient information submitted with your claim, you will have 45 days to supply the Fund Office with the missing information. If you provide the requested information before the expiration of the 45-day period, the Fund Office shall provide its determination within 15 days of receipt. If you fail to provide any or all requested information within the 45-day period, the Fund Office shall provide its determination within 15 days after the 45-day period has elapsed.

Disability Benefit Claims

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

If, prior to the end of the first 30-day extension, the Plan determines that, due to matters beyond the control of the Plan, a decision cannot be made within that extension period, the Plan may take another 30-day extension. If the Plan cannot make a determination because it requires additional information from you, you will have 45 days in which to provide the additional information. If you provide the requested information before the expiration of the 45-day period, the Fund Office shall provide its determination within 30 days of receipt. If you fail to provide any or all requested information within the 45-day period, the Fund Office shall provide its determination within 30 days after the 45-day period has elapsed.

In each extension notice, the Plan must notify you of the reason(s) for the extension and the date on which the Plan expects to make a decision. This notice will also explain the standards used by the Plan in determining whether a participant is entitled to a disability benefit, the unresolved issues preventing a decision on your claim, and if needed, any additional information needed to resolve those issues.

Manner and Content of Notification of Health and Welfare Benefit Determination

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

- The specific reasons for the adverse determination;
- Reference to the specific Plan provision(s) on which the determination was based;
- A description of any additional material or information necessary to perfect (complete) the claim and an explanation of why such material or information is necessary;



- A statement that you are entitled to receive copies of all documents relevant to your claim for benefits, upon request and at no cost to you;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on review;
- If an internal rule, guideline, protocol, or other criterion was relied upon in making the adverse determination, either (1) a copy of such rule, guideline, protocol or other criterion or (2) a statement that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request;
- If the adverse benefit determination was based on medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request;
- In the case of an adverse benefit determination involving a claim for urgent care, a description of the expedited review process applicable to such claims will be provided. The information may be provided to the claimant orally within the time-frame prescribed, provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

Appealing a Denied Claim

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

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

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

Hospital and Medical Benefit Appeals

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



Plan Appeals

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

Any appeal that does not involve urgent care must be in writing, and can be made by you or a duly authorized representative. The appeal must set out the reasons for the appeal and your dissatisfaction or disagreement with the Plan's decision. Any evidence, comments, or documentation to support your position should be submitted with your written appeal.

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

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

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

Appeals of Urgent Care Claims

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



Appeals of Pre-Service Claims

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

Appeals of Post-Service and Disability Claims

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

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

Notification of Benefit Determination on Review

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

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



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

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



THIRD PARTY LIABILITY

BACKGROUND

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

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

Set forth in this section are the details of the Fund's rights to reimbursement and subrogation, and your responsibilities as a Participant or Beneficiary. You may be asked to sign an acknowledgment and agreement as a condition of receiving benefits, in order to confirm your agreement to and your understanding of the Fund's rights and your responsibilities; however, **please note that by accepting the Plan's benefit, you have agreed to and acknowledged these conditions.** Please remember, the purpose of this portion of the Plan of Benefits is to ensure that the Fund's limited funds are not used to provide benefits where other sources of such benefits or compensation may be available. Because this is a self-funded employee benefit plan governed by ERISA and not by state law, this plan may not be deemed to be an insurance company, an insurer, or engaged in the business of insurance for purposes of state law that purport to regulate insurance companies or insurance contracts.

Discretionary Authority

The Plan Administrator shall have sole, full, and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies, or omissions in the Plan and related documents; to make determinations in regard to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participants' rights; and to determine all questions of fact and law arising under the Plan.

1. Where an Injury, Sickness, Disease, or disability is caused in whole or in part by, or results from the acts or omissions of Participants, Plan beneficiaries, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns, or a third party, where another party may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantors of a third party, the Plan will be secondary, not primary. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury,



Sickness, Disease, or disability is caused in whole or in part by, or results from the acts or omissions of Participants or a third party, where another party may be responsible for expenses arising from an incident, and/or other coverage is available.

2. Participants, their attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first- and third-party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Participant agrees the Plan shall have an equitable lien on any funds received by the Participant and/or his or her attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant agrees to include the Plan's name as a co-payee on any and all settlement drafts.
3. In the event a Participant settles, recovers, or is reimbursed by any coverage, the Participant agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant. If the Participant fails to reimburse the Plan out of any judgment or settlement received, the Participant will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

FUND'S RIGHTS

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

2. **RIGHT OF REIMBURSEMENT:** In addition to a right of subrogation, the Fund retains a separate right to be repaid **in full** (in an amount not to exceed the amount of either the benefits provided by the Fund or the amount of your recovery) from any money a Participant or Beneficiary recovers for which the Fund has provided plan benefits. This means that Participants and Beneficiaries must repay the Fund **first dollar** the amount the Fund has paid or provided in plan benefits from any money recovered from a third party (whether by judgment, settlement, lien or otherwise) or from their own insurer for an underinsured and/or uninsured auto insurance claim, even if the recovery is for (or said to be for) a loss other than that for which the Participant or Beneficiary received benefits from the Plan (such as pain and suffering, punitive damages, mental anguish, "special" or any other type of damages), and even if the Participant or Beneficiary does not recover in full on his or her claims. If one is paid by a third party's insurer or one's own insurer (including any underinsured and uninsured auto insurance), one must repay the Fund in full.



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

4. **CONSTRUCTIVE TRUST:** If you (or your attorney or other representative) receives any payment through a judgment, settlement or otherwise - for an illness or injury that is caused by a third party, you agree to maintain the Fund's Right of Reimbursement and Subrogation Rights. As a result, you are required to maintain any and all payments you receive from a third party in a separate, identifiable account and you agree that the Fund has an equitable lien on the funds. In addition, you agree to serve as a constructive trustee over the funds for which the Fund has paid expenses related to that illness or injury. This means that you will be deemed to be in control of, and responsible for, turnover of those funds held back to the Fund.

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

6. **RIGHT TO SET OFF:** Failure by the Participant and/or his/her attorney to comply with any of these requirements may, at the Fund's discretion, result in a forfeiture of payment by the Fund of medical benefits or any other funds/payments due under this plan of benefits on the Participant's (or his/her Beneficiary's), or the payment of amounts due to a third party on the Participant's (or Beneficiary's) until the Participant satisfies his/her obligation to fully reimburse the Fund. As a condition of receiving benefits, Participants (and Beneficiaries) acknowledge and agree to Fund's right to set off and must cooperate with the Fund when it requests information about possible subrogation or reimbursement issues. The Fund may also bring a lawsuit against a Participant, or Beneficiary, to collect on payments already made should the Participant (or Beneficiary) fails/refuses to comply with the Fund's requests to subrogate or to be reimbursed.

PARTICIPANT'S (or Beneficiary's) OBLIGATIONS:

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

- Notify the Fund in writing within ten (10) business days that a Claim relating to such illness or injury has been filed by the Participant or Beneficiary against a third party seeking available funds, and must fully assist and cooperate with the Fund in protecting the Fund's reimbursement and subrogation rights;
- Notify the Fund in writing of the name and address of the Participant's (or Beneficiary's) attorney, provide that attorney with a copy of the Plan and the executed



Acknowledgment and Agreement form, and inform the attorney that they are required to comply with the Plan's terms;

- Keep the Fund informed in writing of the progress and/or settlement of the claim;
- Include in all claims a claim for benefits paid (or to be paid) by the Fund to and/or on behalf of the Participant or Beneficiary, plus interest accruing from the date of payment of such benefit and refuse any settlement or resolution of a claim until the receipt of authorization from the Fund to accept the offered settlement;
- Reimburse the Fund in full for any benefits paid by the Fund to or on behalf of the Participant or Beneficiary, plus interest accruing from the date of payment of such benefits; and
- Require and authorize the attorney to withhold from available funds any monies due the Fund, and to forward the monies to the Fund. In case of any dispute over what monies are due the Fund between the Participant and/or Beneficiary and the Fund, the available funds are to be escrowed pending resolution of the dispute.

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

SUBROGATION

1. As a condition to participating in, and receiving benefits from this Fund, the Participant (or Beneficiary) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the Participant (or Beneficiary) is entitled.
2. If a Participant (or Beneficiary) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant may have against any coverage and/or party causing the injury/illness, to the extent of such conditional payment by the Plan plus reasonable costs of collection.
3. The Plan may, in its own name or in the name of the Participant (or Beneficiary), commence a proceeding or pursue a claim against any party or coverage for the recovery of all damages, to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the Participant (or Beneficiary) fails (or refuses) to file a claim or pursue damages against:
 - a. The responsible party, its insurer, or any other source on behalf of that party;
 - b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured, or underinsured motorist coverage;
 - c. Any policy of insurance from any insurance company or guarantor of a third party;
 - d. Worker's compensation or other liability insurance company; or,
 - e. Any other source, including but not limited to, crime victim restitution funds, any



medical, disability or other benefit payments, and school insurance coverage; the Participant (or Beneficiary) authorizes the Fund to pursue, sue, compromise and/or settle any such claims in the Participant's (or Beneficiary's) name and agrees to fully cooperate with the Fund in the prosecution of any such claims. The Participant (or Beneficiary) assigns all rights to the Fund or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Fund shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant is fully compensated by his or her recovery from all sources. The Fund shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment or rights which interferes with or compromises in any way the Fund's equitable lien and right to reimbursement. The obligation to reimburse the Fund in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant's recovery is less than the benefits paid, then the Fund is entitled to be paid all of the recovery achieved.

OTHER MATTERS

FAULT OF PARTICIPANT/BENEFICIARY: The Fund's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant, whether under the doctrines of causation, comparative fault, or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Fund and will not reduce the Fund's reimbursement rights.

WRONGFUL DEATH: In the event that the Participant (or Beneficiary) dies as a result of his/her injuries, and a wrongful death or survivor claim is asserted against a third party or any coverage, the Fund's subrogation and reimbursement rights shall still apply.

SEPARATION OF FUNDS: Benefits paid by the Fund, funds recovered by the Participant (or Beneficiary), and funds held in trust over which the Fund has an equitable lien are considered by the Fund to exist separately from the property and estate of the Participant (or Beneficiary), such that the death of the Participant (or Beneficiary), or filing of bankruptcy by the Participant (or Beneficiary), will not affect the Fund's equitable lien, the funds over which the Fund has a lien, or the Fund's right to subrogation and reimbursement.

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

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

EXCESS INSURANCE: The Fund's benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of that party;



2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured, or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Worker's compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

If a settlement, judgment, or any other arrangement arising from a claim for or from an incident for which another party is responsible for payment of medical expenses includes compensation and/or coverage for future expenses arising from said incident, the Plan will be excess to said funds. Upon determination that funds will be made available to the Participant (or Beneficiary) for future expenses arising from said incident, the Participant (or Beneficiary) is obligated to advise the Plan of said arrangement. Failure to do so, and/or forwarding claims to the Fund for which another party has accepted responsibility will be considered a violation of the Participant's (or Beneficiary's) obligations to the Fund, as described herein.

ATTORNEYS' FEES: The Fund will **not** reimburse you, as a Participant, or your Beneficiary for any attorneys' fees incurred while pursuing any third-party claim, even if you are successful in your claim (whether by settlement, judgment, lien or otherwise). The Fund expressly disavows the "common fund" and "collateral source" doctrines and any other judicial doctrine that would impose fee splitting between the Fund and the Participant's (or Beneficiary's) attorneys. However, the Fund's equitable lien on the amount owed by the Participant and/or Beneficiary for benefits paid on their behalf may also include any attorney's fees and collection costs that the Fund incurs should it determine to seek either a subrogation or reimbursement claim of the benefits it paid against the third-party tortfeasor.

SCOPE OF RIGHTS: These subrogation and reimbursement provisions will be interpreted by the Trustees, in their sole and final discretion, to permit the Fund to obtain full satisfaction of any lien or right to reimbursement from you or your eligible Dependent or any other person who received payment on your behalf (including, but not limited to, a parent, spouse, guardian or estate). The Trustees may, in their sole discretion, allocate the responsibility for reimbursement or satisfaction of a lien among you, your eligible Dependent, and any other person, such as your or your eligible Dependent's legal counsel.

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



IMPORTANT INFORMATION ABOUT THE WELFARE FUND

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

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

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

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

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

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

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

Plan Year. Plan records are kept on a "Plan Year" basis which runs May 1 through April 30.

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



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

Michael Previtera
Fund Administrator
IUPAT DC21 Benefit Funds
2980 Southampton-Byberry Road
Philadelphia, PA 19154

Legal process may also be served upon individual Trustees at the Fund Office address above.

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

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

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

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

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

Self-funded benefits. Currently, the following benefits are self-funded: medical benefits (Blue Cross or Keystone; with the exception of over 65/Medicare-eligible Retirees); prescription drug benefits (administered by Benecard); dental benefits (administered by Fidelio), vision benefits (administered by National Vision Administrators), and weekly disability benefits (administered by the Fund Office). This means that benefits are paid directly out of Fund assets, rather than through an insurance policy. However, for some of these benefits, the Fund has contracted with an insurance company to administer these benefits – process claims, etc. All third-party administrators are described in the back of the booklet.



YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Office and at other specified locations, such as work locations and union halls, all documents governing the Plan, including summary plan descriptions, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Trustees are required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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



Enforce Your Rights

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

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

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

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory, or:

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

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



HIPAA PRIVACY AND SECURITY RULES

This section describes the manner in which the Fund will utilize and protect certain health information maintained by the Fund to carry out its administrative functions.

The Fund sponsors a group health plan and maintains relationships with certain group health plan providers that are subject to the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") privacy and security rules and regulations which are described more fully in this Document. Under the Privacy and Security rules of HIPAA, and the regulations issued thereunder and so amended by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH") as part of the passage of the American Recovery and Reinvestment Act of 2009 ("ARRA") at 45 CFR Parts 160 and 164 ("the HIPAA regulations"), a group health plan must:

- (i) restrict the use and disclosure of protected health information ("PHI"),
- (ii) ensure the confidentiality, integrity, and availability of all electronic protected health information ("e-PHI") the plan creates, receives, maintains, or transmits,
- (iii) protect against any reasonably anticipated threats or hazards to the security and integrity of such information,
- (iv) protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the HIPAA privacy rules set forth in 45 CFR Part 164, Subpart E, and
- (v) ensure compliance with the HIPAA security rules set forth in 45 CFR Part 164, Subpart C by its workforce.

Definition of Protected Health Information and Electronic Protected Health Information

Protected Health Information ("PHI") shall mean the same as that term so defined by Section 45 C.F.R. 160.103, limited to the information created or received by the Business Associate from, or on behalf of, the Covered Entity. Electronic Protected Health Information ("e-PHI") shall have the same meaning as the term also defined by 45 C.F.R. 160.103 and generally is any Protected Health Information that is created, received, maintained, or transmitted in electronic form.

Disclosure to the Board of Trustees

The Fund (or health insurance issuer or HMO with the Fund's permission) may disclose the PHI to the Board of Trustees that is necessary for the Board to carry out necessary functions related to the administration of the Fund. The Board may be required to access a Covered Member's claim information for the purpose of performing those functions that are designated as "Plan Sponsor" functions under ERISA.

Such functions may include: obtaining premium bids from health plans to provide health insurance coverage to participants under the Fund; and modifying, amending, or terminating the Fund or any benefit provided by the Fund. All other access to PHI by the Board is done pursuant to the Board's capacity as the administrator of the Fund and is described in the HIPAA Policies and Procedures for the Fund. The Board may use and disclose the PHI provided to it from the Fund (or health insurance issuer or HMO) only for the purposes described herein.



Conditions on the Use and Disclosure of PHI

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

- (a) *Prohibition on Unauthorized Use or Disclosure of PHI.* The Board will not use or further disclose any PHI received from the Fund, except as permitted in this document or required by all applicable law for the Plan administration functions described under 45 CFR 164.504(a), to the extent not inconsistent with the HIPAA regulations.
- (b) *Minimum Necessary Standards.* With the exception of such uses and disclosures permitted or required under 45 CFR 164.502, 45 CFR 164.514, and/or by law, the Board will make reasonable efforts to limit the PHI used, disclosed, or requested to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request.
- (c) *Subcontractors and Agents.* The Board will require each of its subcontractors or agents to whom it provides PHI to agree to the same conditions that apply to the Board with respect to such information.
- (d) *Permitted Purposes.* The Board will not use or disclose PHI for employment-related actions and decisions or, in connection with any other of the benefits sponsored by the Board. The Board will also not use or disclose PHI that is genetic information for underwriting purposes.
- (e) *Reporting.* The Board will report to the Fund any impermissible or improper use or disclosure of PHI not authorized by the plan documents of which it becomes aware.
- (f) *Access to and/or correction of PHI by Covered Persons.* The Board will make PHI contained in the designated record set available to the Fund to permit Covered Persons to inspect, copy, amend, and/or carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526.
- (g) *Accounting of PHI.* The Board will make PHI available for purposes of required accounting of disclosures to the Fund for the purposes of satisfying the participant's request for such an accounting in accordance with 45 CFR 164.528.
- (h) *Disclosure to Government Agencies.* The Board will make its internal practices, books and records relating to the use and disclosure of PHI received from the Fund available to the Department of Health and Human Services or its designee for the purpose of determining the Fund's compliance with HIPAA.
- (i) *Return or Destruction of PHI.* If feasible, return or destroy all PHI received from the Fund that the Board still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Board agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- (j) *Adequate Separation.* The Board represents that adequate separation exists between the Plan and Plan Sponsor. The Board represents that only certain individuals, such as the Fund Administrator and those involved in plan administration functions as defined in 45 CFR 164.504(a), are permitted to access PHI received by the Plan. If the Board or any other individual responsible for monitoring compliance determines that any person in this section has failed to maintain adequate separation in handling of PHI, then such person may be subject to disciplinary action. The Board shall also arrange to maintain record of such violations along with those persons involved and the disciplinary/corrective measures taken with respect to the incident.



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

Security of Electronic Protected Health Information

Disclosure to Board of Trustees

The Board of Trustees and Plan will safeguard e-PHI by:

- (a) *Administrative, Physical, and Technical Safeguards.* Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of e-PHI the Board creates, receives, maintains, or transmits on behalf of the Plan.
- (b) *Adequate Separation.* Ensuring that adequate separation between the Plan and other offices or plans of the Union and/or employers as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures.
- (c) *Subcontractors and Agents.* Ensuring that any agent, including a subcontractor such as a benefit provider, to whom it provides e-PHI agrees to implement reasonable and appropriate security measures to protect such information.
- (d) *Reporting.* Report to the security official of the Plan or the security official's designee any Security Incident of which it becomes aware, including notice of a Security Incident received from a benefit provider. Security Incident shall mean the successful unauthorized access to, use, disclosure, modification or destruction of, or interference with, e-PHI.

Exceptions

The security requirements discussed above do not apply to e-PHI that the Board of Trustees receives pursuant to an appropriate authorization that complies with HIPAA regulations and that it receives for the purpose of either: (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending, or terminating the Plan as authorized by the HIPAA Privacy Rules.



PLAN'S HIPAA PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), the Fund must follow detailed federal regulations in gathering, storing and releasing your "protected health information" or "PHI" and your "electronic protected health information" or "e-PHI." Set forth below are the Fund's policy and procedures for handling of that information.

Purpose of This Notice and Effective Date

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

Effective Date: The security requirements of this Section are effective April 21, 2005.

This Notice is Required by Law. THIS NOTICE APPLIES TO THE VARIOUS HEALTH COVERAGE PROGRAMS MADE AVAILABLE TO PARTICIPANTS AND THEIR BENEFICIARIES THROUGH THE INTERNATIONAL UNION OF PAINTERS AND ALLIED TRADES DISTRICT COUNCIL NO. 21 WELFARE FUND, REFERRED TO IN THIS NOTICE AS "PLAN." THE PLAN IS REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF PROTECTED HEALTH INFORMATION AND TO PROVIDE INDIVIDUALS WITH NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION. THIS NOTICE DESCRIBES HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION AND YOUR RIGHTS WITH RESPECT TO THAT INFORMATION. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT THE BENEFITS COORDINATOR USING THE CONTACT INFORMATION LISTED BELOW.

We are required to abide by the terms of this Notice but reserve the right to amend the Notice at any time. Any change in the terms will be effective for all PHI and e-PHI that we maintain at that time. If a change is made to this Notice, a revised Notice will be provided to all persons covered under the Plan at that time.

Protected Health Information (PHI) is individually identifiable information, including demographic information, that the Plan (or your health care provider(s) and insurance carrier(s) as described in this Summary Plan Description) creates, receives, transmits or maintains which is related to your past, present or future physical or mental health care, treatment or condition and to payment for health care. *PHI includes information possessed/provided to/by the Plan which is in oral, electronic or written form.*

USE AND DISCLOSURE OF HEALTH INFORMATION

When the Fund May Disclose Your PHI. If you request it, the Fund is required to give you access to certain PHI in order to allow you to inspect and/or copy it. Under the law, the Fund may disclose your PHI without your consent or authorization, or the opportunity to agree or object, in the following cases



- As required by HHS. The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.
- For treatment, payment or health care operations. The Fund and its business associates will use PHI in order to carry out:
 - Treatment
 - Payment, or
 - Health care operations.

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 Fund may disclose 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 includes but is not limited to actions taken to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations).

For example, the Fund may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund. If we contract with third parties to help us with payment operations, such as a physician that reviews medical claims, we will also disclose information to them. These third parties are known as "business associates." Please refer to "Policy on Business Associates" in Section 4 below for more information on disclosure of PHI to business associates. We will also disclose enrollment information to contributing employers.

Health care operations includes but is 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 Fund may use information about your claims to refer you to a disease management or a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

Disclosure to the Fund's Trustees. The Fund will also disclose PHI to the Plan Sponsor, the Trustees of the Fund, for purposes related to treatment, payment, and health care operations, and will permit this use and disclosure as required by federal law. For example, we may disclose information to the Trustees to allow them to decide an appeal or review a subrogation claim.

When the Disclosure of Your PHI Requires Your Written Authorization. Although the Fund does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Fund will use or disclose psychotherapy notes about you. However, the Fund may use and disclose such notes when needed by the Fund 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.

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, your close personal friends, and any other person you choose under the 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. The Fund is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

1. When required by applicable law.
2. Public health purposes. To an authorized public health authority required, if by law or for public health and safety purposes. 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 Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
4. Health oversight activities. To a 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 healthcare providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
5. Legal proceedings. When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to subpoena or discovery requests that is accompanied by a court order.
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 certain law enforcement purposes, including:
 - 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.



8. Determining cause of death and organ donation. 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. Subject to certain conditions.
11. Health or safety threats. When, consistent with applicable law and standards of ethical conduct, the Fund 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, or to authorized federal officials for lawful intelligence, counter intelligence and other national security activities.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

Other Uses or Disclosures. The Fund may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosure to the Plan Sponsor: The Fund may disclose protected health information to the plan sponsor of the Fund for reviewing your appeal of a benefit claims or for other reasons regarding the administration of this Fund. The "plan sponsor" of this Fund is the Board of Trustees of the International Union of Painters and Allied Trades District Council No. 21.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Plan will not disclose your health information other than with your written authorization. For example, the Plan must obtain your written authorization to use or disclose your PHI for most types of marketing initiatives, or to sell your PHI. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time. The Plan will honor a request to revoke as soon as reasonably possible, to the extent that the Plan has not already used or disclosed the PHI in good faith during the period in which your authorization was valid.

Further, in regard to PHI that pertains to psychotherapy treatment that you may receive, the Plan must obtain your written authorization before the Plan can use or disclose this PHI. However, the Plan may use and disclose such PHI when it is needed by the Plan to defend itself against litigation that you file. Notes about your psychotherapy treatment are separately filed notes related to conversations you may have with your mental health professional (therapist) during a counseling session. These notes do not include summary information about your mental health treatment.



YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

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

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information that are related to treatment, payment and health care operations. You also have the right to request that the Plan restrict the use or disclosure of your PHI to family members or your personal representatives. You have the right to request a limit on the Plan's disclosure of your health information to someone involved in the payment of your care. However, the Plan is not required to agree to your request if, for example, compliance is determined to be unreasonable, for example, compliance with your request could lead to the Plan violating a court order.

If you wish to make a request for restrictions, please contact: Benefits Coordinator at International Brotherhood of Painters and Allied Trades District Council No.21 Welfare Fund, 2980 Southampton-Byberry Road, Philadelphia PA 19154 or by fax to (215) 677-3877.

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

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information that is contained within your designated record set. 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. If the health information you wish to inspect and copy qualifies as psychotherapy notes and/or are a part of information being compiled in the reasonable anticipation of, or for use in, an administrative, civil or criminal action or proceeding, the Plan will not allow you to access that information nor copy it. A request to inspect and copy records containing your health information must be made in writing to Benefits Coordinator at International Brotherhood of Painters and Allied Trades District Council NO.21 Welfare Fund, 2980 Southampton-Byberry Road, Philadelphia PA 19154 or by fax to (215) 677-3877. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. If your request for access is denied, you may have a right to have the decision reviewed.

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



created by the Plan, if the health information you are requesting to amend is not part of your designated record set, if the health information you wish to amend qualifies as psychotherapy notes and/or are a part of information being compiled in the reasonable anticipation of, or for use in, an administrative, civil or criminal action or proceeding, or if the Plan determines the records containing your health information are accurate and complete.

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.

Right to an Accounting. You have the right to request a list of certain disclosures of your PHI from the Plan as so permitted by the Privacy Rule, however, the Plan does not have to provide an accounting of a disclosure in the following instances: (1) to carry out your treatment, payment and health care operations; (2) disclosures made to you or your personal representatives whose authorization to such records have not been restricted by you; (3) incident to disclosures and/or use that is otherwise permissible by law such as those made to a covered entity, law enforcement officials or for national security purposes; (4) disclosure and use of your de-identified information to third-party with whom the Plan has a data use agreement which contains adequate safeguards for use of such de-identified information by that third-party; and (5) disclosures that occurred more than six (6) years prior to your request for the accounting.

Should your PHI be maintained by the Plan in an electronic health record, and the Plan has made use or disclosure of the PHI contained in that electronic health record for treatment, payment or health care operations, you may request an accounting of such disclosures that were made by the Plan no more than three (3) years prior to your request.

The request must be made in writing to Benefits Coordinator at International Brotherhood of Painters and Allied Trades District Council NO.21 Welfare Fund, 2980 Southampton-Byberry Road, Philadelphia PA 19154 or by fax to (215) 677-3877. The Fund will provide the first accounting you request during any 12-month period without charge. The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. Should you need to make additional requests, subsequent accounting requests will be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee.

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

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.



The Fund 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 Fund will recognize certain individuals as personal representatives without the individual having to complete an Appointment of Personal Representative Form. For example, the Fund will automatically consider the member parent or legal guardian as the personal representative of an unemancipated minor except in a few types of situations. A member parent or legal guardian recognized as the personal representative of an unemancipated minor may act on an individual's behalf, including requesting access to their PHI. Unemancipated minors may, however, request that the Fund restrict information that goes to family members as described above at the beginning of Section 3 of this Notice.

The Fund will not automatically consider a spouse to be the personal representative of an individual covered by the Fund. A spouse may not act on an individual's behalf, including requesting access to their PHI, without completing an Appointment of Personal Representative Form. If an Appointment of Personal Representative Form has been completed by the spouse, the individual covered by the Fund may request that the Fund restrict information that goes to family members as described herein.

POLICY ON BREACH OR UNSECURED PROTECTED HEALTH INFORMATION

This Section applies to breaches of "Unsecured PHI."

Definitions. The following definitions shall apply in this Section:

1. "Unsecured PHI" shall mean information that is not secured through the use of a technology or methodology identified by the Secretary of the Department of Health and Human Services to render such PHI unusable, unreadable and undecipherable to unauthorized users. Unsecured PHI may be written, or in electronic form. The following types of information shall not be considered Unsecured PHI, and the following types of information are therefore not subject to the policy set forth in this Section:
 - (i) De-identified health information, which, by definition set forth in the Privacy Standards at 45 C.F.R. §164.502(d)(2), is not PHI.
 - (ii) PHI which is encrypted according to an encryption algorithm and for which there is security of the decryption key or process. The encryption key must be kept on a separate device from the encrypted data to ensure that the key is not breached.
 - (iii) PHI which has been destroyed, i.e., there has been destruction of the media on which the PHI is stored or received so that (1) paper, film or other copy have been shredded such that PHI cannot be read or reconstructed, or (2) electronic media have been cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitation.

NOTE: Redaction does not satisfy the requirement for destruction. However, if all identifiers have been redacted, so that the information is de-identified, by definition, it is not PHI.

2. "Breach" shall mean the unauthorized acquisition, access, use or disclosure of PHI in a manner not permitted by the HIPAA Privacy Standards which compromises the security or privacy of the



PHI, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information. To determine whether a breach has occurred, the following questions must be answered as part of a risk assessment to determine the probability that PHI has been compromised:

- (i) Is the disclosure impermissible under the HIPAA Privacy Regulations?
- (ii) Does the unauthorized activity pose a significant risk of financial, reputational or other harm to the individual?
- (iii) What is the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification?
- (iv) Who are the unauthorized persons who receive the PHI or use it improperly?
- (v) Will immediate steps to mitigate the likelihood of unauthorized access to the PHI reduce or eliminate the risk to the affected individuals?
- (vi) Was the impermissibly disclosed PHI returned prior to being accessed for an improper purpose?

Notice to Affected Individuals of Breach. The Fund will notify each affected individual by first class mail or by e-mail (if the person has indicated a preference to receive information by e-mail), of any breaches of Unsecured PHI as soon as possible, but in no event later than thirty (30) days following the discovery of the breach. In urgent cases, an alternative form of notification, such as by telephone, may be used in conjunction with the written notification.

Exceptions to Individual Notification Requirement. The individual notification requirement set forth in the previous paragraph shall not apply in the following circumstances:

1. Unintentional acquisition, access or use of PHI by an individual acting under the Fund's authority or under the authority of a one of the Fund's business associates, provided that such unintentional activity was done in good faith, within the course of employment or other professional relationship and does not result in further use or disclosure that is not permitted by the HIPAA Privacy Standards.
2. Inadvertent disclosure of PHI by a person working for the Fund with authority to access PHI, or a business associate to another person or entity who also has authority to access PHI, provided the recipient is part of the Fund or the business associate, as applicable, and provided the recipient does not further disclose the information in violation of the HIPAA Privacy Standards.
3. Unauthorized disclosures where, based on the good faith belief of the disclosing person, the recipient to whom the PHI is disclosed would not reasonably have been able to retain the information.

Posting Notice of Breach. If a breach of Unsecured PHI involves ten (10) or more individuals whose contact information is out of date, the Fund will post a notice of the breach on the Plan Sponsor's website or in a major print or broadcast media.

Contacting Media Outlets. If a breach involves more than five hundred (500) individuals in a state or jurisdiction, the Fund will send notices to prominent media outlets serving those areas.



Notification of media outlets is not required if no one state has more than five hundred (500) affected individuals.

Notice to the Secretary. If a breach involves fewer than five hundred (500) individuals, the Fund will notify the secretary of the Department of Health and Human Services within sixty (60) days of the date upon which such breach was disclosed. If a breach involves more than five hundred (500) individuals, irrespective of whether a state has more than five hundred (500) affected individuals, the Fund will immediately notify the Secretary of the Department of Health and Human Services.

Contents of Notice. The notices required under this policy shall include all of the following:

- A brief description of the breach, including the date of the breach and the date of its discovery, if known;
- A description of the types of Unsecured PHI involved in the breach;
- Steps an affected individual should take to protect himself/herself from potential harm resulting from the breach;
- A brief description of the actions the Fund is taking to investigate the breach, mitigate losses, and protect against further breach;
- Contact information, including a toll-free telephone number, e-mail address, website or postal address to permit affected individuals to ask questions or obtain additional information; and
- Any sanctions imposed on any individual involved in the breach.

DUTIES OF THE PLAN TO MAINTAIN YOUR PRIVACY

The Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy by mail of the revised Notice to you within sixty (60) days of the change.

Any revised version of this notice will be distributed by mail 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 Fund;
- Other privacy practices stated in this notice; or
- Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund 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 United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA;
- Uses or disclosures required by law;
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy Regulations; and
- Uses or disclosures made pursuant to your written authorization.

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 Fund 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.

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the following officer:

Michael Previterra or his Designee
IUPAT DC21 Health & Welfare Fund
2980 Southampton-Byberry Road
Philadelphia, PA 19154
(215) 698-0978

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services ("HHS"). Please contact the nearest office of the Department of Health and Human Services listed in your telephone directory, visit the HHS website at www.hhs.gov or contact the Fund Administrator (or his Designee) for more information about how to file a complaint. The Fund will not retaliate against you for filing a complaint.



HEALTH REIMBURSEMENT ACCOUNT – PLANS A, B, E, F, G, N, HA & AP

A Health Reimbursement Account (HRA) is an expense account that consists of funds set aside to reimburse qualified medical expenses including future retiree contributions and Medicare Part B premiums. This HRA applies only to those members who are maintain their eligibility to participate in Plans A, B, E, F, G, N, HA and AP.

Who is eligible to participate in the HRA?

Requirements for Initial Eligibility for Plans A, B, E, F, G, N, HA and AP

You are eligible to participate in the HRA as an Active Participant if you work in “Covered Employment”. Your participation will be effective on the 1st of the month following your work in “Covered Employment”.

Please note: If you do not have sufficient number of hours to be eligible for a normal health plan, or you do not provide proof of coverage under another health plan, you will not qualify for a health care reimbursement from the HRA.

Requirements for Continued Eligibility for Plans A, B, E, F, G, N, HA and AP

Once initial eligibility is met, you will continue to have access to your HRA provided that there is an account balance and you are working in “Covered Employment,” or considered to be Retired, as described in the Eligibility Section. Credits will only be allocated while you are working in “Covered Employment”.

If you leave “Covered Employment” and are not considered to be Retired, you will have access to your account until the balance in your HRA is exhausted **provided** a five (5) year period has not lapsed since the last contribution into your account **and provided** you do not work for a non-union employer performing work which would otherwise be considered “Covered Employment” if the employer were an employer with a collective bargaining agreement with IUPAT District Council 21. If you no longer meet the requirements for continued access to your HRA, the remaining money in your HRA will be forfeited.

How will the Health Reimbursement Account Work?

Your account will be funded by credits. Each year an hourly contribution allocation will be determined for the Health Reimbursement Account. For illustrative purposes, we will use \$0.25 per hour as the hourly contribution allocation. If you work 160 hours in a month, then you would be credited with \$40 (160 x \$0.25) for that month in your personal HRA. The contributions will be credited to your account monthly as they are received by the Fund Office.

Credits will be allocated for hours worked while you are establishing initial eligibility or reestablishing eligibility after a lapse.



What is an “eligible expense?”

An “eligible expense” means any expense identified as an Eligible Medical Expense that is further described below. You may not submit a claim for an amount that has been deducted on your prior year’s personal tax return or that was incurred prior to the date you became eligible to participate in the HRA, nor shall you be entitled to submit a claim for any other expenses that have been paid through any other health insurance plan, Section 125 “cafeteria” plan, or other similar medical expense reimbursement arrangement. If you provide proof of coverage from another insurance plan, you are eligible to get HRA reimbursement. If you do not have any Health coverage, then you are not entitled to HRA reimbursement. Please review the list of eligible medical expenses included on the claim form for assistance in determining what is generally accepted as an “eligible expense.”



What are the eligible expenses under the Health Reimbursement Account?

The Plan shall reimburse only the following eligible medical expenses as such expenses are defined in Internal Revenue Code Section 213(d). The minimum claim amount that may be submitted for a reimbursement request is \$200. Smaller expenses may be combined to meet the \$200 minimum requirement. Nonetheless, the total amount of reimbursement is limited to the total amount that you have accrued in your account at the time your request for reimbursement is submitted. You must submit your claim to the Fund Office within one (1) year of the date the service(s) that would qualify.

- Dental expenses such as:
 - Balance billings from non-participating dentists;
 - Eligible dental services beyond the annual maximum provided through the dental benefits;
 - Coinsurance amounts for services eligible through dental benefits;
- Vision expenses such as:
 - Balance billings from non-participating vision providers;
 - Eye examination, corrective vision surgery, lenses and glasses outside the frequency provided through the Vision benefits;
- The inpatient hospitalization and outpatient surgery copays associated with the Personal Choice benefits;
- The copayment associated with the brand and generic medications along with any applicable difference in cost between the brand and the generic medication, if you elect to take a brand medication when a generic is available;
- COBRA insurance premium;
- Retiree contributions;
- Medicare Part B premiums;

Does the Plan also provide benefits for my family?

The Plan provides reimbursement for expenses incurred for you and your Dependents as described in the Eligibility Section.



Does my coverage under this Plan end when I leave Covered Employment?

After you leave Covered Employment, your normal participation will end when there are no hours credited to your account. However, you may still receive reimbursement of any eligible expenses, as otherwise provided for under the Plan, provided you meet the criteria set forth in Requirements for Continued Eligibility and provided your account has a positive balance.

What happens to the balance in your account if you die?

If you die, your Eligible Dependents may still receive reimbursement of any eligible expenses, as otherwise provided for under the Plan, until there is no account balance **provided** a five (5) year period has not lapsed since the last contribution into your HRA.

How do I receive reimbursement?

You may submit claim reimbursement requests to the Fund Office.

The minimum claim amount that may be submitted for a reimbursement request is \$200. Smaller expenses may be combined to meet the \$200 minimum requirement. Nonetheless, the total amount of reimbursement is limited to the total amount that you have accrued in your account at the time your request for reimbursement is submitted.

To have your claims processed as soon as possible, please read and follow the claims instructions that have been furnished to you by the Plan. You must submit your claim to the Fund Office within one (1) year of the date the service(s) that would qualify as an “eligible expense” was obtained.

When must the expenses be incurred that I may be reimbursed for?

Eligible expenses must have been incurred after the date the Plan became effective. You may not be reimbursed for any expenses arising before the Plan became effective, or prior to the time you became covered under the Plan, if later.



How do you file a claim?

When you incur a qualifying expense, you are responsible for paying the provider. You then submit a copy of your paid invoice along with your claim form to:

The IUPAT District Council 21 Fund Office
2980 Southampton-Byberry Road
Philadelphia, PA 19154

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

This benefit is not a vested benefit and the trustees may, change, alter, modify or discontinue the benefits described herein at any time.

The trustees have the authority to interpret this plan of benefits and any facts related to a claim for benefits and the interpretation of the trustees shall be conclusive on the participant and anyone claiming by, for or on behalf of a participant.



LMCI MATERNITY LEAVE PROGRAM

LMCI has approved funding for a maternity leave program to be administered by local health and welfare funds. The program provides a benefit of 6-weeks of paid leave for all working participants who give birth. If the participant gives birth by caesarean section, the paid leave may be extended to 8 weeks. Further, if a participant is certified by their health care provider as being unable to work during their pregnancy, they may receive up to 6 months of paid leave prior to giving birth.

The weekly benefit amount is based on two-thirds (2/3) of the participant's regular weekly pay, up to a maximum of \$800 per week. Weekly earnings shall be determined based on the participant's hourly wage for a 40-hour work week.

Benefit payments are calculated using the following formula:

66.67% of Normal Hourly Wage x 2080 ÷ 52 = Weekly Benefit (\$800 cap)

Benefits shall be calculated at the rate of 1/7 of the weekly benefit for each day of total disability if the participant is totally disabled for less than a full week.

- **Eligibility Criteria.** To be eligible for reimbursement from this program, the participant must meet the following criteria.
 - **Only available to participants on whose behalf contributions are made to the IUPAT District Council No. 21 Welfare Plan. This reimbursement program is not available to any dependents, meaning spouses and children, of Fund participants.**
 - Participant cannot use this benefit more than once within a twenty-four (24) month period.
 - For pre-delivery leave only, if a participant is unable to perform the duties of their trade due to physical limitations associated with their pregnancy, the participant must submit certification from their physician to the Fund Office which verifies their inability to work due to these limitations.

- **Time Periods for Eligibility.**
 - Pregnancy (Pre-Delivery/Birth):
 - For the benefits to commence prior to delivery/birth, the participant must be certified as unable to work by their physician. This certification must indicate that the participant is not able to work due to physical limitations arising from the pregnancy, ***however, please note that eligibility for the benefit shall not begin until the onset of the fourth (4th) month of pregnancy.***
 - This cumulative pre-delivery/birth benefit may be intermittent and shall not exceed six (6) months. After six (6) months, the benefit payments will stop regardless of whether the participant is able to return to work or not.
 - The Fund, at the request of the LMCI, shall require submission every two (2)



months by the participant of a recertification of their continued inability to work, as provided from the participant's physician during the pregnancy.

- Post-Delivery/Birth:
 - Regardless of the benefits paid by the Fund during the participant's pregnancy, the participant will be eligible for up to six (6) weeks of paid leave after the birth of their child, with an additional two (2) weeks available if the birth was performed by cesarean.

Ineligibility. The LMCI Maternity Leave Program is unavailable to the following individuals:

- Dependents (Spouses and Children) of Fund Participants
- IUPAT DC21 members who do not receive contributions made on their behalf to the Fund (e.g., retirees)
- Surrogate-related pregnancies
- Adoption of a child
- Foster care arrangements



ADMINISTRATION AND CONTACT INFORMATION

- Plans A, B, E, F, G, N, HA, NEP, RES, SP and AP

BENEFIT	TYPE OF ADMINISTRATION	TYPE OF FUNDING
Hospital and Medical	Independence Blue Cross 1901 Market Street Philadelphia, PA 19103 215-557-7577 www.ibx.com	The Fund pays premiums to Blue Cross and Keystone and the carriers provide benefits.
Prescription Drug	Benecard Services, LLC 5040 Ritter Road Mechanicsburg, PA 17055 800-672-7723 www.benecardpbf.com	Benecard provides administrative services and the Fund pays for benefits.
Dental	Fidelio Dental Insurance Company 2826 Mount Carmel Avenue Glenside, PA 19038 215-885-2443 1-800-262-4949 www.Fideliodental.com	Fidelio provides administrative services to the Fund, and the Fund pays for benefits.
Vision Services	NVA 1200 Route 46 West Clifton, NJ 07013 800-672-7723 www.e-nva.com	NVA provides administrative services to the Fund, and the Fund pays for benefits.
Weekly Disability Benefit	District Council No. 21 Welfare Fund 2980 Southampton-Byberry Road Philadelphia, PA 19154 215-934-5130	The Fund administers and provides benefits.
Life Insurance	Amalgamated Insurance Company Administrative Office 333 West Chester Ave. White Plains, NY 10604 914-367-5361	The Fund pays premiums to Amalgamated, and Amalgamated provides benefits.
Accidental Death and Dismemberment Benefits	Amalgamated Insurance Company Administrative Office 333 West Chester Ave. White Plains, NY 10604 914-367-5361	The Fund pays premiums to Amalgamated, and Amalgamated provides benefits.
Health Reimbursement Account	District Council No. 21 Welfare Fund 2980 Southampton-Byberry Road Philadelphia, PA 19154 215-934-5130	The Fund administers and provides benefits.



ADMINISTRATION AND CONTACT INFORMATION – PLAN L

BENEFIT	TYPE OF ADMINISTRATION	TYPE OF FUNDING
Hospital and Medical – Keystone POS	Independence Blue Cross 1901 Market Street Philadelphia, PA 19103 215-557-7577 www.ibx.com	The Fund pays premiums to Blue Cross and Keystone and the carriers provide benefits.
Prescription Drug	Benecard Services, LLC 5040 Ritter Road Mechanicsburg, PA 17055 800-672-7723 www.benecardpbf.com	Benecard provides administrative services and the Fund pays for benefits.
Dental	Fidelio Dental Insurance Company 2826 Mount Carmel Avenue Glenside, PA 19038 215-885-2443 1-800-262-4949 www.Fideliodontal.com	Fidelio provides administrative services to the Fund, and the Fund pays for benefits.
Vision Services	NVA 1200 Route 46 West Clifton, NJ 07013 800-672-7723 www.e-nva.com	NVA provides administrative services to the Fund, and the Fund pays for benefits.
Weekly Disability Benefit	District Council No. 21 Welfare Fund 2980 Southampton-Byberry Road Philadelphia, PA 19154 215-934-5130	The Fund administers and provides benefits.
Life Insurance	Amalgamated Insurance Company Administrative Office 333 West Chester Ave. White Plains, NY 10604 914-367-5361	The Fund pays premiums to Amalgamated, and Amalgamated provides benefits.
Accidental Death and Dismemberment Benefits	Amalgamated Insurance Company Administrative Office 333 West Chester Ave. White Plains, NY 10604 914-367-5361	The Fund pays premiums to Amalgamated, and Amalgamated provides benefits.



ADMINISTRATION AND CONTACT INFORMATION – PLAN T&X

BENEFIT	TYPE OF ADMINISTRATION	TYPE OF FUNDING
Hospital and Medical	Independence Blue Cross 1901 Market Street Philadelphia, PA 19103 215-557-7577 www.ibx.com	IBX provides administrative services and the Fund pays for benefits.
Prescription Drug	Benecard Services, LLC 5040 Ritter Road Mechanicsburg, PA 17055 800-672-7723 www.benecardpbf.com	Benecard provides administrative services and the Fund pays for benefits.
Dental	Fidelio Dental Insurance Company 2826 Mount Carmel Avenue Glenside, PA 19038 215-885-2443 1-800-262-4949 www.Fideliodontal.com	Fidelio provides administrative services to the Fund, and the Fund pays for benefits.
Vision Services	NVA 1200 Route 46 West Clifton, NJ 07013 800-672-7723 www.e-nva.com	NVA provides administrative services to the Fund, and the Fund pays for benefits.
Weekly Disability Benefit	District Council No. 21 Welfare Fund 2980 Southampton-Byberry Road Philadelphia, PA 19154 215-934-5130	The Fund administers and provides benefits.
Life Insurance	Amalgamated Insurance Company Administrative Office 333 West Chester Ave. White Plains, NY 10604 914-367-5361	The Fund pays premiums to Amalgamated, and Amalgamated provides benefits.
Accidental Death and Dismemberment Benefits	Amalgamated Insurance Company Administrative Office 333 West Chester Ave. White Plains, NY 10604 914-367-5361	The Fund pays premiums to Amalgamated, and Amalgamated provides benefits.



ADMINISTRATION AND CONTACT INFORMATION – PLAN Y&Z

BENEFIT	TYPE OF ADMINISTRATION	TYPE OF FUNDING
Hospital and Medical	Independence Blue Cross 1901 Market Street Philadelphia, PA 19103 215-557-7577 www.ibx.com	IBX provides administrative services and the Fund pays for benefits.
Prescription Drug	Benecard Services, LLC 5040 Ritter Road Mechanicsburg, PA 17055 800-672-7723 www.benecardpbf.com	Benecard provides administrative services and the Fund pays for benefits.
Dental	Fidelio Dental Insurance Company 2826 Mount Carmel Avenue Glenside, PA 19038 215-885-2443 1-800-262-4949 www.Fideliodental.com	Fidelio provides administrative services to the Fund, and the Fund pays for benefits.
Vision Services	NVA 1200 Route 46 West Clifton, NJ 07013 800-672-7723 www.e-nva.com	NVA provides administrative services to the Fund, and the Fund pays for benefits.
Weekly Disability Benefit	District Council No. 21 Welfare Fund 2980 Southampton-Byberry Road Philadelphia, PA 19154 215-934-5130	The Fund administers and provides benefits.
Life Insurance	Amalgamated Insurance Company Administrative Office 333 West Chester Ave. White Plains, NY 10604 914-367-5361	The Fund pays premiums to Amalgamated, and Amalgamated provides benefits.
Accidental Death and Dismemberment Benefits	Amalgamated Insurance Company Administrative Office 333 West Chester Ave. White Plains, NY 10604 914-367-5361	The Fund pays premiums to Amalgamated, and Amalgamated provides benefits.