Massachusetts Laborers' Health and Welfare Fund

A Summary of Plan Features

Massachusetts Laborers' Health and Welfare Fund

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This booklet is your Summary Plan Description (SPD) of the Plan. The SPD is intended to explain the major provisions of the Plan in simplified language.

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Consultants and Actuaries	The Segal Company
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Foreign Language Notice

Este folleto contiene un resumen en inglés de sus derechos y beneficios del Plan bajo el Massachusetts Laborers' Health and Welfare Fund (Fondo de Salud y Bienestar de Massachusetts Laborers). Si usted tiene dificultad para entender cualquier parte de este folleto, comuníquese con la Oficina del Fondo en 14 New England Executive Park, Burlington, MA 01803-0900, o llame al 781-272-1000. Las horas de oficina son de 8:30 A.M. a 4:30 P.M., lunes a viernes.

Este livreto contém um sumário em idioma inglês dos direitos e benefícios do seu Plano, segundo o Massachusetts Laborers' Health and Welfare Fund (Fundo de Saúde e Bem-estar dos Trabalhadores do Massachusetts). Caso tenha dificuldade para compreender qualquer parte do presente livreto, contate o Escritório do Fundo, no endereço: 14 New England Executive Park, Burlington, MA 01803-0900, ou ligue para o número: 781-272-1000. O horário de funcionamento do escritório é: das 8:30 às 4:30.

Date of This Edition
The information in this SPD is based on the Plan rules in effect as of January 1, 2008.

January 1, 2008

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Suite 200, P.O. Box 4000
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www.MLBF.org

We are pleased to present you with this new Summary Plan Description (SPD) of your benefits under the Massachusetts Laborers' Health and Welfare Fund.

This new edition has been prepared to make it easy for you to find the information you need about your benefits. Here are some of its features:

- A "Contacts" chart for quick reference (see page iii);
- An overview of the benefits available (see page 1);
- "Fast Facts" at the beginning of each chapter to give you a broad sense of what's contained within the section; and
- A chapter on life events (adding a dependent to your family, absence from employment for military service, etc.) that may involve your benefits.

While we are committed to providing health care benefits that include treatment of illnesses, we cannot stress too strongly how important it is for all of us to take charge of our health. One way to do that is to take advantage of the "wellness" benefits that are included in your benefits program:

- Annual physical exams;
- Prenatal care and assistance managing the risks of pregnancy;
- Affordable prescription drugs for conditions requiring medications;
- A Member Assistance Program to help you deal with the problems of life;
- Preventive dental care—oral exams, x-rays, and cleanings and, for children, fluoride treatment, sealants, and space maintainers; and
- Comprehensive eye exams.

As you read the rest of this summary, you will see the above items discussed in more detail. You should familiarize yourself with each of these programs to maximize the benefits available to you and your family.

Questions?

Please read this SPD carefully and keep it handy for future reference. If you are covering dependents under the Plan, please share the information in the SPD with them. If you have any questions about the Plan after reading this SPD, please contact the Fund Office at the address or telephone numbers above or visit our Web site at www.MLBF.org.

Sincerely,

BOARD OF TRUSTEES

Contacts

The Fund Office—www.MLBF.org To help you with your questions about: eligibility information, claims assistance, or COBRA	781-272-1000 or 800-342-3792
BlueCross BlueShield—www.BCBS.com Help in finding PPO providers for medical Plan services, preferred providers for home health care and durable medical equipment, and assistance managing the risks of pregnancy and obtaining required pre-authorizations.	To locate a PPO Provider: 800-810-2583 Pre-authorizations: 800-327-6716
The Wellness Corporation	
• Member Assistance Program (MAP)—Required pre-authorizations for treatment of mental health conditions, alcoholism, and substance abuse	800-522-6763
• Complementary Medicine—Required pre-authorizations for massage therapy, oriental medicine, biofeedback, homeopathy, nutrition and naturopathy	800-522-6763
Express Scripts—www.express-scripts.com	
• Help in finding a network pharmacy	800-467-2006
• Mail-order prescription service	800-233-7139
• If pre-authorizations are required for certain drugs, have your physician call 800-417-8164 or send a fax to 800-357-9577	
Delta Dental—www.deltamass.com Questions about dental benefits and assistance finding participating dentists	800-872-0500 or 617-886-1234
Davis Vision—www.davisvision.com Questions about vision benefits and assistance finding network providers	800-999-5431

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Overview of the Available Benefits

The benefits available to active participants and their dependents are summarized in the chart below.

Benefit	Description
Medical	Benefits for a wide array of services, from hospital and physician services to durable medical equipment. A network provider feature can help you keep your share of the costs down.
Prescription drugs	Covers generic and brand-name prescription drugs after you pay $5, $15, or $25 per prescription at retail pharmacies. Also offers a mail-order service for maintenance drugs at a reduced cost, with copayments.
Member Assistance Program	Assistance with personal and family difficulties, mental health-related conditions, alcoholism and substance abuse.
Dental	Benefits for preventive care (exams, cleanings, etc.). Plan A also includes basic and major restorative care (from fillings to dentures) and orthodontia benefits for children under age 19. A network provider feature can help you keep your share of the costs down.
Vision care	Benefits for an eye exam, spectacle lenses, and a frame once every 24 months (once every 12 months for children under age 19) if you use a Davis network provider. If you use a network provider, you can keep your share of the costs down.
Hearing device	$800 for a hearing device per ear, once every five years.
Weekly accident and sickness (for members only)	Pays a weekly income-replacement benefit of up to $273 when illness or injury prevents you from working. Benefits start on 1st day of disability if the disability is caused by an accident or on the 8th day of disability if the disability is caused by an illness and can be paid for up to 13 weeks.
Life insurance (for members only)	Pays $10,000 to your beneficiary in the event of your death.
Accidental death and dismemberment (for members only)	Pays another $10,000 to your beneficiary if you should die from an accident. It pays up to $10,000 to you if you lose limbs or sight in an accident.

Benefits for Retirees

The Fund offers the following benefits for **qualified** retirees and their eligible dependents:

- A self-pay medical and dental plan; and
- A death benefit in the event of the **qualified** retiree's death.

Eligibility for Coverage

This section explains the rules that govern participation in the Plan.

FAST FACTS:

- The number of hours you work in covered employment determines your eligibility for Plan A or Plan B.
  - Plan A—**1,000 recorded hours** within a 12-month Qualifying Period = coverage during a 6-month Eligibility Period
  - Plan B—**700 recorded hours** within a 12-month Qualifying Period = coverage during a 6-month Eligibility Period

When Your Participation Begins

You are eligible to participate in the Massachusetts Laborers' Health and Welfare Plan based on the number of hours you work in covered employment. As of January 1, 2007, there are two benefit plans available for active members—Plan A or Plan B.

Your eligibility to participate in Plan A or Plan B for each 6-month Eligibility Period will depend on the number of recorded hours of employment you accumulate with one or more contributing employers within a period of 12 consecutive months.

Eligibility Requirements

- Plan A—**1,000 recorded hours** within a 12-month Qualifying Period = coverage during a 6-month Eligibility Period
- Plan B—**700 recorded hours** within a 12-month Qualifying Period = coverage during a 6-month Eligibility Period

FIRST QUALIFYING PERIOD REQUIREMENT FOR JANUARY THROUGH JUNE ELIGIBILITY PERIOD

12-Month Qualifying Period												Collection Lag for Employer Contributions			6-Month Eligibility Period					
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun

SECOND QUALIFYING PERIOD REQUIREMENT FOR JULY THROUGH DECEMBER ELIGIBILITY

12-Month Qualifying Period												Collection Lag for Employer Contributions			6-Month Eligibility Period					
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Example:
Your eligibility during the 6-month Eligibility Period beginning January 1, 2008 will depend on the number of recorded hours of employment you accumulated during the 12-month Qualifying Period beginning on October 1, 2006, and ending on September 30, 2007. If you work 1,000 or more hours, you will be eligible for Plan A. If you work 700 hours, but fewer than 1,000 hours, you will be eligible for Plan B.

Continuing Your Eligibility

Once you meet the eligibility requirements for either Plan A or Plan B, your participation will continue as long as you work at least 1,000 hours for Plan A or 700 hours for Plan B in a 12-month Qualifying Period for the next 6-month Eligibility Period. Your dependents' participation will end when your coverage does or, if earlier, when they no longer meet the eligibility requirements.

ABSENCES FROM EMPLOYMENT

See "Life Events," starting on page 37, for information on how military service or an absence under the Family and Medical Leave Act will affect benefits coverage.

Reciprocity

After June 30, 2005, should you work in Rhode Island or Connecticut, any contributions remitted to the Rhode Island or Connecticut Funds will be reciprocated back to the Massachusetts Laborers' Fund on your behalf, provided you are a member of a Maine, New Hampshire, Vermont or Massachusetts Local Union.

In order to have contributions exchanged in a timely manner, whenever you work outside the states of Maine, Massachusetts, New Hampshire and Vermont you must contact the Fund Office.

Should you wish contributions for your work in Rhode Island or Connecticut to stay with those Funds, you have the option to elect not to have your contributions reciprocated. You should either contact the Fund Office in the state where you are working to advise them you do not authorize the transfer of contributions to your Home Fund in Massachusetts or contact the Massachusetts Fund Office to obtain a form that will permit you to elect not to have your contributions transferred. You can only make one election per twelve-month period.

Please be aware that amounts you pay toward deductibles under the health care plans are not transferable between funds.

You may not receive benefits from more than one Laborers' fund in New England at the same time. However, if you have elected not to transfer the contributions to Massachusetts and are entitled to benefits under more than one Laborers' fund, the benefits will be coordinated. See "Coordination of Benefits" on page 40 for more information.

Dependent Eligibility

Your dependents' eligibility will start when your eligibility starts or, if later, on the date they become your qualified dependents (see "Frequently Asked Questions" on page 10). You may cover the following dependents under the Plan's health care benefits:

- the spouse to whom you are legally married (including a spouse who is the same gender as you, if the state where you live allows you to legally marry each other);
- your unmarried children under 19 years of age; and
- your unmarried children over 19 years of age, but less than 23 years of age, who are enrolled as full-time students in an accredited school, college, or university and who are dependent on you for financial support. Student verification must be provided to the Fund Office each semester to confirm full-time status and continuity of attendance. (*Orthodontia benefits are available only for dependent children up to 19 years of age.*)

Please note that you will be responsible for reimbursing the Fund for claims paid if your dependent child fails to maintain full-time student status.

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

In order for the Plan to consider a child an eligible dependent, the child must have the same principal place of abode as you for over half of the year, and must be dependent on you for over half of their support. Proof that you provide over half of their support must be furnished to the Plan upon request.

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

If a child for whom you are the legal guardian is not related to you (in the manner described in Section 152(d)(2)(A) through (G) of the Internal Revenue Code), he or she must have the same principal place of abode as you for the entire year and must be considered a member of your household.

CHANGES IN DEPENDENT ELIGIBILITY

You are responsible for notifying the Fund Office if a dependent ceases to be eligible for coverage.

Disabled Children

You may be able to cover a disabled child beyond the age he or she would otherwise lose eligibility. To do so, you will need to provide the Fund with proof that the child is mentally or physically handicapped, so as to be incapable of earning his own living, and is dependent upon you for over half of their support.

You will need to provide this proof before or within 31 days after the child reaches the age where coverage would otherwise terminate. Medical proof of handicapped status must be provided annually or as requested by the Trustees. The child's exemption from the age requirement can continue for as long as his or her incapacity continues.

Same-Sex Spouses

You may cover a spouse who is the same gender as you if the state where you live allows you to legally marry each other. You may also cover such a spouse's eligible dependent children provided that such dependent children meet the definition of eligible dependent(s) identified on page 3 under Dependent Eligibility. As part of the enrollment process, you will need to submit a marriage certificate to the Fund, as well as birth certificates, adoption documents or legal guardianship documents for any qualified dependent children.

Taxes on Coverage of Same-Sex Spouses

Federal law requires that you pay Federal income and FICA (Social Security and Medicare) taxes on the value of the coverage provided to your same-sex spouse (and his or her eligible dependent children, if applicable). You will need to send a payment for each eligibility period to the Fund—for transmission to the IRS—in advance of your spouse's receiving coverage. The Fund Office will notify you of the amount due. If you are a Fund Office employee, payment of these taxes will be withheld from your pay.

If You Enter Military Service

If you enter active qualified military service in the uniformed services of the United States while eligible for Fund coverage, you and your eligible dependents can continue to be covered during your active military service.

For this to happen, you must submit a copy of your military induction orders to the Fund Office upon entering active military service.

Your eligible dependents will continue to be covered as long as they continue to meet the Plan's definition of "dependent" (see page 3). Your dependents may also be eligible for military health coverage called TRICARE; if so, the Fund will coordinate its benefits with TRICARE.

Continued coverage under the Fund will NOT include:

- coverage for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during performance of service in the uniformed services (*the uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities*);
- weekly accident and sickness benefits; or
- life insurance or accidental death and dismemberment benefits, if the loss is caused directly or indirectly, in whole or in part, by a war or an act of war.

When you are honorably discharged from "service in the uniformed services," or have discharge orders from active duty or a DD Form 214, the eligibility that you had remaining under Plan A or Plan B prior to entering military service will be reinstated, or if greater, six months of eligibility will be allowed, provided that you report back to work or apply for reemployment within the time frame allowed by law, as outlined in the accompanying chart.

The Plan provisions that apply if you enter military service comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA) and, in some respects, provide more than what USERRA requires.

TIME FRAME FOR RETURNING TO WORK AFTER MILITARY SERVICE

Length of Military Service	Reemployment Deadline
Less than 31 days	At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (allowing travel time plus eight hours)
31 through 180 days	Within 14 days after discharge
More than 180 days	Within 90 days after discharge or as otherwise required by law

If you are hospitalized or convalescing from an injury caused by active duty, these time limits can be extended for up to two years.

Make sure you adhere to the provisions for returning to covered employment after your military service ends.

Retiree Eligibility for Benefits

You may be eligible for continuing medical and dental benefits after you retire, and your beneficiary may be eligible for a death benefit if you die after retiring.

See "Retiree Benefits" on page 36 for more information.

COBRA Continuation of Health Care Coverage

COBRA provides an option for temporarily continuing coverage under Plan A or Plan B if you lose eligibility.

FAST FACTS:

- You will lose eligibility for coverage as an active participant if you are short work hours during a qualifying period or retire.
- Your dependents will lose eligibility when you do. They can also lose eligibility earlier, for other reasons.
- Depending on the reason for the loss of eligibility, you or your dependents could continue health care coverage under COBRA for 18 – 36 months.
- You will pay the full cost of your COBRA continuation coverage.

COBRA Continuation Coverage

You and your eligible dependents have the right to continue your health care coverage (medical, dental, and vision) under this Plan on a self-pay basis if coverage would otherwise terminate because of a qualifying event. This provision does not apply to life insurance, accidental death and dismemberment benefits, weekly accident and sickness benefits, or extended medical benefits for a disability.

Qualifying events are shown in the accompanying chart. You may continue only the health care coverage (under Plan A or Plan B) that was in effect at the time of the qualifying event. The only exception is if your qualifying event is retirement on or after January 1, 2007 (see page 7).

COBRA CONTINUATION COVERAGE

COBRA Qualifying Event	Who May Continue Benefits	Maximum Period of Continuation Coverage
You lose eligibility due to • working less than 1,000 hours in a 12-month Qualifying Period (for Plan A) or 700 hours in a 12-month Qualifying Period (for Plan B) • retirement	You, your spouse, and/or your dependent children covered under the Plan	18 months*
You die	Your spouse and/or your dependent children covered under the Plan	36 months
You divorce or legally separate from your spouse	Your former spouse and/or your dependent children covered under the Plan	36 months**
Your child ceases to meet the Plan's definition of an eligible dependent (for example, because of marriage or a change in age or student status)	The affected dependent child who was covered under the Plan	36 months
You become entitled to Medicare (Under Part A, Part B, or both)	Your spouse and/or your dependent children covered under the Plan	36 months

* Disability extension: Coverage for all enrolled family members may be continued an additional 11 months (for a total of 29 months) if you or a covered dependent becomes totally disabled before or during the first 60 days of COBRA continuation coverage. See "Extended COBRA Period for Disability" later in this section.

** See the description of "Continuation Coverage Rights because of divorce or legal separation" on page 8.

Effect of prior Medicare enrollment: If the shortage of hours or retirement occurs less than 18 months after the date you become entitled to Medicare (Part A, Part B, or both), the maximum period of continuation coverage for your dependents covered under the Plan will be 36 months after the date of your Medicare entitlement.

Qualified Beneficiaries

Under the law, only "qualified beneficiaries" are entitled to COBRA continuation coverage. A qualified beneficiary is any individual who was covered under the Plan on the day before the COBRA qualifying event by virtue of being a participant on that day, the spouse of a participant, or the dependent child of a participant. Same-

sex spouses have the same continuation rights as opposite-sex spouses do under COBRA.

A child who becomes a dependent child by birth, adoption, placement for adoption, or legal-guardian appointment during a period of COBRA continuation coverage and is enrolled within 31 days is also a qualified beneficiary and will have the same COBRA rights as a spouse or children who were covered by the Plan before the qualifying event that triggered the COBRA continuation coverage.

A spouse who becomes your spouse during a period of COBRA continuation coverage may be added to your coverage during the period you remain eligible for COBRA continuation coverage. (See "Special COBRA Enrollment Rights" later in this section.) However, such a new spouse would not be a qualified beneficiary (in other words, would not have any independent enrollment rights or be eligible for additional months of coverage if one of the "second qualifying events" described below occurred).

Extended COBRA Period for Disability

If you lose eligibility because of a shortage of hours or retirement and you or one of your covered dependents is determined by the Social Security Administration to have been totally disabled at the time of the qualifying event or within 60 days of the qualifying event, coverage may be extended for you and all enrolled dependents beyond the original 18 months up to 29 months.

See the "Member Notification Responsibilities" section for information on procedures and time frames for notifying the Fund Office of Social Security Administration determinations.

Please note that the premium for the additional 11 months can be approximately 50% higher than the initial 18-month COBRA premium.

If a Second COBRA Qualifying Event Occurs

If your dependents are in an 18-month COBRA continuation coverage period because of your shortage of hours or retirement (or a 29-month period, in the case of disability) and one of the following qualifying events occurs, the maximum COBRA continuation period for your dependents will switch to 36 months (provided you and/or your dependents notify the Fund Office of the second qualifying event within the time frame discussed in "Member Notification Responsibilities" below):

- you get divorced or legally separate;
- you die; or
- your child ceases to meet the Plan's definition of an eligible dependent (in this case, only the child may extend coverage).

For example:

Tom stops working (the first COBRA qualifying event) and enrolls himself and his family in COBRA continuation coverage for 18 months. Three months after his COBRA continuation coverage begins, Tom's child turns 19 and no longer qualifies as a dependent child under the Plan's definition. Tom's child can continue COBRA coverage for an additional 33 months, for a total of 36 months of COBRA continuation coverage.

Participants are not entitled to COBRA continuation coverage for more than a total of 18 months (unless you are entitled to an additional 11 months' continuation coverage because of a disability). Even if you experience a shortage of hours followed by retirement, the retirement is not treated as a second qualifying event and you may not extend your coverage.

Member Notification Responsibilities

You and/or your dependents are responsible for providing the Fund Office with timely notice of the following qualifying events:

Qualifying Event	Notification Deadline
1. Your divorce or legal separation* 2. A child no longer qualifies as a "dependent child" 3. A second qualifying event	*For events 1–3:* No later than 60 days after the later of (1) the date of the relevant qualifying event or (2) the date on which coverage would be lost under the Plan as a result of the qualifying event.
4. A qualified beneficiary is determined to be disabled by the Social Security Administration	*For event 4:* No later than 60 days after the latest of: the date of the disability determination by the Social Security Administration; the date on which the qualifying event occurs; or the date on which the individual loses (or would lose) coverage under the Plan as a result of the qualifying event, and before the end of the first 18 months of continuation coverage.
5. Determination by the Social Security Administration that the qualified beneficiary is no longer disabled	*For event 5:* No later than 30 days after the date of the Social Security Administration determination that the qualified beneficiary is no longer disabled.

* Note: see the "Continuation Coverage Because of Divorce or Legal Separation" section on page 8.

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

The Fund Office will notify you of your right to choose continuation coverage within 60 days of receiving notification of a qualifying event. This notice will be sent to your last address on file at the Fund Office. A notice will be sent to an eligible dependent at an address that is different from the member's address only if a different address has been provided to the Fund Office.

How to Provide Notice to the Fund Office

To provide the Fund Office with notice of any of these five qualifying events, you must request a COBRA application form. You can obtain a copy of the form by contacting the Fund Office or by visiting our Web site at www.MLBF.org. No other form of notice will be accepted by the Fund. If you have any questions about how to fill out this form, please contact the Fund Office at 781-272-1000 or 800-342-3792.

Where to Send the Notice

Notice should be sent by U.S. mail to the following address:

COBRA Department
Massachusetts Laborers' Health and Welfare Fund
14 New England Executive Park, Suite 200
P.O. Box 4000
Burlington, MA 01803-0900

Please keep a copy, for your records, of any notices you send to the Fund Office.

Who Can Provide Notice

Notice may be provided by the qualified beneficiary with respect to the qualifying event (you or your dependents, as applicable) or any representative acting on behalf of the 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 you, your spouse, and your child are all covered by the Plan and your child ceases to be a dependent under the plan, a single notice sent by you or your spouse would satisfy this requirement.

If you or your dependents send a notice to the Fund Office as described above and the Fund Office determines that you are not entitled to COBRA continuation coverage, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA continuation coverage. This will be provided within 14 days after the Fund Office receives your notice.

Fund Office Notification Responsibilities

When the qualifying event is the loss of eligibility (due to working less than 1,000 hours (Plan A) or 700 hours (Plan B) in a 12-month Qualifying Period or retirement), the death of the member or the member becoming entitled to Medicare benefits (under Part A, Part B, or both), the Fund will determine when a qualifying event has occurred. For the other qualifying events listed on page 6, you must notify the Fund Office.

Electing Coverage

The COBRA continuation coverage you are able to elect will be based on the coverage you were eligible for at the time of your qualifying event (excluding retirement, see below) as follows:

- If you had coverage under Plan A, and you are *not* eligible for Plan B at the time of your loss of eligibility, the Fund will extend Plan A COBRA continuation rights.
- If you had coverage under Plan B, the Fund will extend Plan B COBRA continuation rights.

If your qualifying event is retirement under the Massachusetts Laborers' Pension Fund, on or after January 1, 2007, you will have the ability to elect either Plan A COBRA or Plan B COBRA continuation coverage for you and your eligible dependents regardless of the coverage you had before retirement.

You and/or your covered dependents have **60 days** to make your COBRA election from the later of:

- the date you would have lost coverage because of the qualifying event; or
- the date you received the election form and COBRA information from the Fund Office.

Participants may elect one of the following types of coverage under Plan A COBRA or Plan B COBRA:

1. Core only;
2. Core plus dental; or
3. Core plus dental and vision.

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

A parent or legal guardian may elect COBRA continuation coverage for a minor child. If you or your spouse elects COBRA continuation coverage, you will be deemed to be electing it for your eligible dependent children as well, unless you specify otherwise in the election. If you and your spouse do not elect COBRA continuation coverage, your dependent children will be able to elect it or reject it independently of your rejection.

If you and/or your dependents do not elect COBRA within the 60-day period allowed, you will forfeit all rights to COBRA continuation coverage and your health care coverage will end.

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under Federal law:

- First, if you have a gap in health coverage of 63 days or more, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans (election of COBRA continuation coverage may prevent such a gap).
- Second, if you do not get continuation coverage for the maximum time available to you, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions.
- Finally, you have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer). Special enrollment under this provision is allowed within 30 days after your group health coverage ends because of the qualifying events listed on page 5 or at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

You do not have to show that you are insurable to choose COBRA coverage.

60-DAY DEADLINE FOR ELECTING COVERAGE

If you do not elect COBRA continuation coverage within the 60 days allowed, you will forfeit your right to COBRA continuation coverage.

You may not elect any coverage you did not have immediately before the qualifying event, unless you retire under the Massachusetts Laborers' Pension Fund. See Electing Coverage on page 7.

Your initial continuation coverage will be identical to coverage provided to similarly situated individuals under the Plan on the day prior to the qualifying event. If benefits change for active participants, your coverage will change as well.

Cost of Continuation Coverage

COBRA continuation coverage is available only at your own expense. If you elect continuation coverage, you will be charged the full cost to the Plan, plus an administrative charge.

Premiums are approximately 50 percent higher during a disability extension (see "Extended COBRA Period for Disability" earlier in this section).

Sending in Payment

You must send your first payment within 45 days following submission of the COBRA election form. This initial payment must include the cost of coverage retroactive to the first day your coverage would have otherwise terminated.

Your subsequent payments must be made within 30 days after the first of the month in which coverage is provided.

PAYING YOUR COBRA PREMIUMS

Payments must be made continuously and without interruption. Failure to make the monthly payment when due will result in the termination of your health coverage. Retroactive payments will not be permitted under any circumstances.

Continuation Coverage Because of Divorce or Legal Separation

Continuation coverage is extended to an ex-spouse without regard to COBRA continuation coverage because the Fund has chosen to follow continuation coverage provisions based on those described in Massachusetts law. Such alternative coverage may affect the duration of the maximum COBRA coverage period.

Specifically, if your spouse's coverage terminates because of a divorce or legal separation, your former spouse may continue coverage under this Plan, unless the court decree provides otherwise. However, a former spouse's coverage will terminate on the earlier of:

1. the date your coverage under this Plan terminates:
2. the date of either your or your former spouse's remarriage; or
3. at such time as provided by the court decree.

YOU MUST INFORM THE FUND OFFICE IF YOU OR YOUR FORMER SPOUSE REMARRIES.

If a member's ex-spouse loses his or her coverage under the Plan because of any of the three reasons above within 36 months after the parties' divorce, the ex-spouse may maintain COBRA continuation coverage for the remainder, if any, of the 36-month period that began on the date of divorce. In no case is the ex-spouse entitled to COBRA continuation coverage for more than the remainder, if any, of the 36-month period that began on the date of divorce.

Special COBRA Enrollment Rights

Special enrollment for the balance of your COBRA period is also allowed for dependents who lose other coverage. For this to occur,

- your dependent must have been eligible for COBRA coverage on the date of the qualifying event but declined when enrollment was previously offered because he or she had coverage under another group health plan or had other health insurance coverage;
- your dependent must exhaust the other coverage, lose eligibility for it, or lose employer contributions to it; and
- you must enroll that dependent by sending an enrollment form to the Fund Office within 31 days after the termination of the other coverage or contributions.

Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA continuation coverage.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will end on the first of the following dates:

- the date the 18-, 29-, or 36-month maximum continuation period expires;
- the date the required premium is due and unpaid after the applicable grace period;
- the date the person receiving the coverage becomes covered under any other group medical plan (unless the other group health plan will not cover or limits coverage for a pre-existing health condition of that person);
- the date the person receiving the coverage becomes entitled to Medicare benefits;
- the date the Plan terminates; or
- (*for participants under the 11-month disability extension*) the date the Social Security Administration determines that an individual on extended disability coverage is no longer disabled (this applies only to the 19th through 29th month of disability extended coverage).

If COBRA continuation coverage is terminated before the end of the maximum continuation period, the Fund Office will send you a written notice as soon as practicable following its determination that COBRA continuation coverage will terminate. The notice will set out the reason COBRA continuation coverage will be terminated early and the date of termination.

RETIREE MEDICAL PROGRAM

If your qualifying event was retirement and you enrolled in COBRA continuation coverage, you may be eligible for further continuation of your coverage under the Retirees' Self-Pay Medical Program. See page 36.

Questions About COBRA?

If you have any questions regarding COBRA continuation coverage, please contact the COBRA Department at the Massachusetts Laborers' Health and Welfare Fund, 14 New England Executive Park, Suite 200, P.O. Box 4000, Burlington, MA 01803-0900; telephone 781-272-1000 or 800-342-3792.

If you change your marital status or add new dependents, or if you or your spouse or other dependents change addresses, please notify the Fund Office immediately.

RESPONSIBILITY FOR CONTINUING COVERAGE

The Fund assumes no responsibility or liability if you allow your coverage to terminate. If you have any reason to believe that your eligibility will or has terminated, it is your responsibility to contact the Fund Office to verify your eligibility status.

Certificate of Creditable Coverage

When your medical, dental, and vision coverage ends, the Fund Office will provide you and/or your eligible dependents with a certificate of coverage that indicates the period of time you were eligible under the Plan.

If you become eligible for coverage under another group health plan or buy a health insurance policy within 62 days after your coverage under this Plan ends, the certificate you receive from the Fund Office can reduce any exclusion for pre-existing conditions under that group health plan or health insurance policy. The certificate will indicate the period of time you were eligible under our Plan and certain additional information as required by law.

The certificate will be sent to you and/or your eligible dependents by first-class mail shortly after your coverage under this Plan ends. If you elect COBRA continuation coverage, another certificate will be sent by first-class mail shortly after the COBRA continuation coverage ends.

You or a dependent may also request a copy of the certificate at any time within 24 months after your coverage terminates.

Conversion of Life Insurance

Participant life insurance may be converted to individual policies at the participant's expense when coverage ends. See page 34 for more information.

Frequently Asked Questions

Do I need to do anything to enroll in the Plan?

Yes, you will need to complete an enrollment form to provide information about yourself and your dependents. Copies of your marriage certificate, children's birth certificates or adoption documents, or legal **guardianship documents will also be required. You also need to designate a beneficiary for your life insurance and Accidental Death and Dismemberment benefits.**

If you will be covering a same-sex spouse, you will also need to send payments for the tax due on the value of the coverage (see page 4).

If you acquire new dependents after enrolling (for example, you get married, have a child, have legal guardianship or adopt a child), you may add the new dependent(s) to your coverage. Contact the Fund Office for information on enrolling new dependents.

You are also responsible for notifying the Fund Office if a dependent ceases to be eligible for coverage under the Plan—***if you divorce or legally separate from your spouse, remarry, or a child reaches a limiting age, gets married, or stops going to school full-time.***

Failure to provide this information in a timely manner will result in the member being responsible to reimburse the Fund for payments made on behalf of ineligible dependents. If the participant does not make proper restitution to the Fund, future benefits will not be paid.

Do I have to undergo a physical exam before I can be covered?

No, you do not need to have a physical exam before being covered.

Medical Plan

This section describes Plan provisions for hospitalization, major medical, doctor treatment, complementary care and how the preferred provider network works.

FAST FACTS:

- Using a provider who participates in the PPO Network will keep your expenses to a minimum.
- Certain services require pre-authorization.
- Your participation in Plan A or Plan B is determined by the number of hours you work in a 12-month Qualifying Period.

Your medical benefits provide coverage for diagnosis and treatment of non-occupational illnesses and injuries, as well as certain preventive care. Included are visits to the doctor, hospitalization, surgery, and treatment for mental illness or substance abuse, among other things.

The accompanying chart is intended to provide a convenient quick-reference guide to selected medical benefits. The percentages shown as payable by the Fund apply to **covered charges only**—the negotiated rate (for PPO providers) or the reasonable and customary charges (for non-PPO providers).

Unless noted otherwise, all benefit payments discussed below are after the deductible. More detailed information, including conditions for payment of different benefits, follows the chart.

QUICK REFERENCE GUIDE FOR SELECTED MEDICAL EXPENSES

	How It Works			
	Plan A		Plan B	
Provision	PPO Provider	Non-PPO Provider in PPO Area	PPO Provider	Non-PPO Provider in a PPO Area
Maximum Lifetime Benefit	$1 million per individual		$1 million per individual	
Annual Deductible per Calendar Year	$250 per individual; $500 per family	$750 per individual; $1,500 per family	$500 per individual; $1,000 per family	$1,000 per individual; $2,000 per family
Hospital and Emergency Care				
Hospital-Inpatient & Ambulatory Surgical Facility (per admission)	Fund pays 100% of the first $50,000 plus 85% of the excess charges with an out-of-pocket maximum of $2,000	Fund pays 90% of the first $50,000 plus 75% of the excess charges with an out-of-pocket maximum of $7,000	Fund pays 100% of the first $7,500 plus 85% of the excess charges with an out-of-pocket maximum of $5,000	Fund pays 90% of the first $7,500 plus 75% of the excess charges with an out-of-pocket maximum of $7,000
Hospital-Outpatient	Fund pays 100% after $15 copayment	Fund pays 80% of R&C fees for most procedures	Fund pays 90% after $15 copayment	Fund pays 75% of R&C fees for most procedures
Emergency Treatment	Fund pays 100% after $75 additional copayment for each emergency medical treatment (waived if admitted to the hospital), and after the initial $15 copayment	Fund pays 80% of R&C fees, after $75 copayment for each emergency medical treatment (waived if admitted to the hospital)	Fund pays 100% after $75 additional copayment for each emergency medical treatment (waived if admitted to the hospital), after the initial $15 copayment	Fund pays 75% of R&C fees, after $75 copayment for each emergency medical treatment (waived if admitted to the hospital)
General Medical Care				
Annual Physical Exam (must be at least one year old)	Fund pays 100% in network after $15 copayment (no deductible)		Fund pays 100% in network after $15 copayment (no deductible)	

Provision	How It Works			
	Plan A		Plan B	
	PPO Provider	Non-PPO Provider in PPO Area	PPO Provider	Non-PPO Provider in a PPO Area
Hearing Services:				
• Device	Fund pays $800 for a hearing device per ear, once every five years		Fund pays $800 for a hearing device per ear, once every five years	
• Exam	Paid same as physician office visit		Paid same as physician office visit	
Physician Office Visit and Surgeon's Expenses	Fund pays 100% after $15 copayment	In most cases, Fund pays 80% of R&C fees	Fund pays 90% after $15 copayment	In most cases, Fund pays 75% of R&C fees
Maternity and Well Baby Care				
Maternity Care	Paid same as other Plan A medical treatment		Paid same as other Plan B medical treatment	
Well Baby Care	Paid same as other Plan A medical treatment		Paid same as other Plan B medical treatment	
Certified Midwifery and Birthing Centers	Fund will pay 100% of the charges for services of a certified nurse midwife or birthing center provided the services or supplies would have been covered had treatment been rendered by any other duly licensed practitioner or at a hospital			
Special Infant Formula	The Fund will pay 70% of the charges, up to a maximum benefit of $1,000 per quarter for infants up to 12 months			
Additional Medical Care				
Mental Health Care: Must be pre-authorized by the Member Assistance Program (The Wellness Corporation)				
• Inpatient (maximum 25 days per calendar year)	Paid same as other Plan A inpatient care		Paid same as other Plan B inpatient care	
• Outpatient (maximum 24 visits per calendar year)	For visits after first eight visits under the MAP, Fund pays 100% after $15 copayment per visit		For visits after first eight visits under the MAP, Fund pays 100% after $15 copayment per visit	
Treatment of Alcoholism or Substance Abuse: Must be pre-authorized by the Member Assistance Program (The Wellness Corporation)				
• Inpatient (25 days max per lifetime)	Paid same as other Plan A inpatient care		Paid same as other Plan B inpatient care	
• Outpatient ($1,500 max per calendar year)	For visits after first eight visits under the MAP, Fund pays 100% of first $500 in covered charges and 80% of remaining covered charges		For visits after first eight visits under the MAP, Fund pays 100% of first $500 in covered charges and 80% of remaining covered charges	
Complementary Care (see page 16 for complete list, pre-authorization requirements and visit limitations)	Fund will pay 80% of the provider's charge, up to a maximum benefit of $50 per visit		Fund will pay 80% of the provider's charge, up to a maximum benefit of $50 per visit	
Outpatient physical, occupational and speech therapy	Fund pays 100% after $15 copayment	Fund pays 80% of reasonable and customary fees	Fund pays 90% after $15 copayment	Fund pays 75% of reasonable and customary fees
Hospice Care	The Fund will pay 100% of the charges certified by BlueCross BlueShield for covered services and supplies for up to a six-month period			
Home Health Care	The Fund will pay 100% of the charges certified by BlueCross BlueShield for visits made by a home health care agency for care at home for up to 90 visits per calendar year			
Durable Medical Equipment (pre-authorization required by BlueCross Blue-Shield and limits apply)	Plan provides benefits for the purchase or rental of certain durable medical equipment for up to $5,000, renewable annually			

All claims must be submitted to the Fund Office no later than 90 days from the date of service. **Do not pay the physician or hospital, other than your copayment, before you receive an Explanation of Benefits (EOB) from the Fund Office.**

The Plan Deductible

The Plan deductible is the amount that you must pay each calendar year toward your covered medical expenses before the Plan will begin to pay medical benefits. All medical expenses, whether in network or out of network, are subject to the Plan deductible. (There is one exception: annual physical exams are not subject to the deductible.) The annual Plan deductibles are:

Plan A Annual Deductible		Plan B Annual Deductible	
PPO Provider	Non-PPO Provider in PPO Area	PPO Provider	Non-PPO Provider in PPO Area
$250 per individual	$750 per individual	$500 per individual	$1,000 per individual
$500 per family	$1,500 per family	$1,000 per family	$2,000 per family

If you move from Plan A to Plan B, or vice versa, during a calendar year, your payments toward your deductible will accumulate. For example:

- If you have met the individual $250 calendar-year PPO Provider deductible for Plan A and then switch to Plan B for the next six-month Eligibility Period, you must pay an additional $250 to meet the individual $500 calendar-year PPO Provider deductible for Plan B.
- If you have met the $500 individual calendar-year PPO Provider deductible for Plan B and then switch to Plan A for the next six-month Eligibility Period, you automatically meet the $250 individual calendar-year PPO Provider deductible for Plan A.

Lifetime Maximum for Benefit Payments

The Fund will not pay more then $1 million for all covered expenses incurred by an individual in his lifetime. This lifetime maximum applies to both Plan A and Plan B.

Preferred Provider Organization (PPO) Providers

The Fund has entered into an arrangement with a Preferred Provider Organization (PPO) that contracts with hospitals, physicians and other health care providers to provide you and your dependents with medical services at discounted rates.

The Fund's PPO is BlueCross BlueShield of Massachusetts for most medical expenses. The Wellness Corporation and the Member Assistance Program (MAP) cover mental health and substance abuse issues and complementary care.

To receive the highest benefit level (in-network benefits) under the Plan, you need to choose providers who participate in the BlueCross BlueShield PPO Provider network. BlueCross BlueShield offers many types of plans with different networks of providers. There are some BlueCross BlueShield providers who do not participate in the PPO network of providers, services will be considered out-of-network, and will be paid at out-of-network benefit levels.

Since there are always changes occurring with the professional services network, it is strongly suggested that you ask a provider if they are participating members of your specific state BlueCross BlueShield Preferred Provider Organization, or access the BlueCross BlueShield Web site (www.BCBS.com) to obtain a provider's current network status prior to receiving care. In addition, at any time you can find out if any provider is a member of the network by contacting the Fund Office or by calling the telephone number on your ID card. Updated provider lists are available from the Fund Office free of charge.

If your physician is not in the PPO network, you may request that BlueCross BlueShield contact him or her about joining it.

If your physician does not have privileges at a PPO hospital, ask him or her to consider getting privileges.

In an Emergency

If you need to use a non-PPO provider in an emergency, the Fund will pay benefits at the level that would have been payable if you had used a PPO provider. Covered charges will be limited to reasonable and customary charges.

Required Pre-Authorizations

The Fund requires pre-authorization for certain services, as summarized in the accompanying chart on page 14.

If you fail to comply with the requirements, the penalty could range from a $250 reduction (for an inpatient admission) in the amount paid by the Fund to a complete denial of the claim (for all other services requiring pre-authorizations).

PLAN REQUIREMENTS FOR PRE-AUTHORIZATION

Situation	Pre-Authorization Requirement
Non-emergency admission to a hospital	You or your doctor must contact BlueCross BlueShield for pre-authorization **at least 10 days before** admission.
Admission to a skilled nursing facility	You or your doctor must contact BlueCross BlueShield for pre-authorization **at least 10 days before** you are admitted.
Emergency admission to a hospital	You or someone acting on your behalf must contact BlueCross BlueShield **within 48 hours** of admission so that it can approve the hospital stay as soon as possible after admission.
Admission to a hospital for childbirth	You and your obstetrician or certified mid-wife should call BlueCross BlueShield to pre-certify the hospital stay well in advance and should call again **within 48 hours** following admission. If the date of admission is rescheduled or cancelled, you also must call BlueCross BlueShield to advise it of the new admission date. You do NOT need pre-authorization for a hospital stay for a mother and newborn child if the hospital stay does not exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section.
Complementary care	You or your provider must call The Wellness Corporation to get pre-authorization **before** you visit the provider.
Hospice care	You or your doctor must call BlueCross BlueShield to get pre-authorization **before** you make any arrangements for hospice care.
Home health care	You or your doctor must call BlueCross BlueShield to get pre-authorization **before** you make any arrangements for home health care.
Mental health treatment	You must call the Member Assistance Program to get pre-authorization **before** admission to a facility or visits to a provider.
Treatment for alcoholism or substance abuse	You must call the Member Assistance Program to get pre-authorization **before** admission to a facility or visits to a provider.
Durable medical equipment	You or your doctor must call BlueCross BlueShield to get pre-authorization **before** you purchase or rent any durable medical equipment.
Gastric bypass surgery	Your doctor must call BlueCross BlueShield to get pre-authorization **before** you make any arrangements for gastric bypass surgery.

The Wellness Corporation (mental and nervous and substance abuse) or BlueCross BlueShield (inpatient hospital stay) will also conduct concurrent review of your hospital stay once you are admitted and help you plan your discharge.

Response Time

Requests for pre-authorization are usually considered “pre-service claims.” Decisions are generally made within 15 days (or 30 days if The Wellness Corporation, BlueCross BlueShield or the Member Assistance Program (MAP) needs more time, or later still if it needs more information from you or your doctor). Decision-making will be expedited if your case warrants treatment as an “urgent care claim,” meaning that following the time frames just described for pre-service claim decisions:

- could seriously jeopardize your life or health or your ability to regain maximum function; or
- in the opinion of a physician with knowledge of your condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the request for pre-authorization.

A decision on a case meriting treatment as an urgent care claim will be made within 72 hours. You or your physician should alert The Wellness Corporation, BlueCross BlueShield or MAP if your pre-authorization request needs to be handled as an urgent care claim. (“Urgent care claims” are not to be confused with emergency treatment or treatment at an urgent care facility, which do not require pre-authorization.)

Intent of Required Pre-Authorizations

The pre-authorizations required under the Plan work to control your costs, for example, by preventing unnecessary hospitalization and hospital stays that extend beyond the time it is medically safe to discharge a patient.

You should note the following, however:

- Neither the Fund nor The Wellness Corporation, BlueCross BlueShield or MAP is responsible for either the quality of health care services actually provided or for the results if a member chooses not to receive health care services that are denied pre-authorization;
- All treatment decisions rest with you and your physician. You should follow whatever course of treatment you and your physician believe to be the most appropriate, although benefits payable by the Fund may be affected by the pre-authorization program; and
- The pre-authorization program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Pre-authorization does not necessarily mean benefits will be paid. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, if the services were not covered by the Plan, or the maximum benefit had already been paid.

If the services for which you are requesting pre-authorization are not approved, you may still proceed with obtaining them. Be aware, however, that the Fund may pay reduced benefits for them or no benefits at all.

You may also appeal an adverse decision. See "Claims and Appeals Procedures" on page 57.

Emergencies

In a medical emergency, you should seek the necessary treatment immediately.

Benefits for emergency medical treatment are paid the same as benefits for other medical treatment. Remember, however, that you or someone acting on your behalf must call BlueCross BlueShield to report an emergency hospitalization within 48 hours of admission if you want to avoid the possibility that your benefit payment will be reduced.

What the Plan Covers

Covered services and supplies include those described in the following pages. Exclusions and limits that apply to specific services and supplies are described with those services and supplies; others are described in the "General Limits and Exclusions" on page 45.

Except as noted in the "General Limits and Exclusions," the Plan will not pay benefits for any expenses related to an occupational injury or illness.

The billed charges that will be considered covered expenses will never be more than the negotiated rate (if you use a PPO provider) or the reasonable and customary charges.

You will be responsible for your share of covered expenses and any amounts that exceed covered expenses. Non-PPO providers are under no obligation to limit their charges to amounts considered covered expenses under the Plan.

If you move from Plan A to Plan B, or vice versa, your claim will be paid based on the Plan you were covered under on the date services were received. However, if you are hospitalized, your claim will be paid based on the Plan you were covered under on the date you were admitted to the hospital.

All benefit payments are subject to the Plan's maximum lifetime benefit.

Hospital and Ambulatory Surgical Facility Charges

The Plan provides benefits for a hospital stay, outpatient services, or ambulatory surgical services. To receive the maximum benefits for these services, be sure to contact BlueCross BlueShield for necessary pre-authorizations (see page 14 for a list). The services eligible for reimbursement under the Plan include:

Covered

- Charges resulting from your inpatient stay in a

hospital. This includes charges for a semi-private room or an intensive care or similar unit. If you have a private room, even if your physician has ordered it, only charges equivalent to the hospital's average semi-private room-and-board charge are covered. You are responsible for the rest of the bill.

- Charges resulting from your confinement as an inpatient in an extended care facility, provided you are admitted within 24 hours after your discharge from a hospital confinement.
- Outpatient charges for a surgical operation.
- Physician copayments are covered for in-hospital physician visits.
- Outpatient charges for emergency treatment within 48 hours following an accidental bodily injury.
- Pre-admission testing—diagnostic tests and x-rays ordered by a physician if the charges are eligible expenses and the tests and x-rays are conducted in the outpatient department of a hospital within seven days of an actual admission to a hospital for treatment of the condition which made the tests necessary. If the admission does not take place, the testing may still be covered if the admission is postponed or cancelled for one or more of the following reasons:
  - the tests show a condition requiring medical treatment, prior to admission;
  - a medical condition develops that delays the admission;
  - a hospital bed is not available on the scheduled date of admission; or
  - the tests indicate that, contrary to the attending physician's expectations, the admission is not necessary.
- Expenses incurred for the use of an ambulatory surgical facility are covered as an in-hospital service. The benefit payable will not exceed the hospital expense benefit.

For successive hospital confinements to be considered separate admissions, they must be due to entirely unrelated causes or separated by an interval of six months or more, or you must have returned to active work for at least one full working day, for members only. Charges made by a hospital will be deemed to include charges made by an anesthetist for the administration of anesthesia, charges by a professional ambulance service to and from the hospital and charges by a radiologist or pathologist.

Surgical Expenses

Covered

All generally accepted surgical procedures, including sterilization procedures (vasectomies and tubal ligations) are covered by the Plan. The Plan also covers gastric bypass surgery. To receive the maximum benefits for surgical services, be sure to contact BlueCross BlueShield for necessary pre-authorizations. (See the "Non-emergency admission to a hospital" section of the pre-authorization chart on page 14 for details.)

Special Provisions Regarding Women's Care

The Plan complies with Federal laws that guarantee certain rights to women:

- Under the Women's Health and Cancer Rights Act of 1998, all plans that cover mastectomies are also required to cover related reconstructive surgery. Available reconstructive surgery must include both reconstruction of the breast on which surgery was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage must also be available for breast prostheses and for the physical complications of mastectomy, including lymphedemas. These services are elective and are chosen by the patient in consultation with the attending physician. They are subject to a plan's usual deductible and copayment provisions.

Not Covered

- Cosmetic surgery, except as required because of accidental injury or reconstructive surgery following a mastectomy.

Complementary Care

The Wellness Corporation provides benefits for certain, non-traditional services and treatments. To receive the benefits for these services, be sure to contact The Wellness Corporation for necessary pre-authorizations. In addition, The Wellness Corporation can refer you to quality complementary care providers when you call for your required pre-authorization.

Complementary care that requires pre-authorization from The Wellness Corporation:

Limitation: There is a *combined* limit of 40 visits per calendar year for all of these services:

- Biofeedback
- Homeopathy
- Massage therapy (these visits can make up no more than 12 of the 40 under the combined limit)
- Naturopathy
- Nutrition
- Oriental medicine

Complementary care that *does not* require pre-authorization:

Limitation: 30 visits per calendar year

- Acupuncture (from a state-certified acupuncturist)

Complementary care that requires utilization of the BlueCross BlueShield PPO network:

Limitation: 30 visits per year

- Chiropractic

Physician Office Visit

The Plan covers routine office visits and any x-rays and/or lab services.

Annual Physical Exam

The Plan covers routine, annual physicals for participants who are at least one year old. If your physician does not do all the testing in his or her office, make sure you submit itemized bills for tests or x-rays with your claim.

Covered

- Services rendered in the ordinary course of a physical examination and not for diagnosis or treatment of an illness or injury
- Measurements of height, weight, hearing, blood pressure and pulse
- Urinalysis
- Blood chemistry (including blood sugar and blood cholesterol), PSA
- Electrocardiogram
- Mammograms
- Chest x-rays
- Lung capacity
- Pelvic examinations
- Pap tests for females
- Colonoscopy

Maternity Care

Special Provisions Regarding Women's Care

The Plan complies with Federal laws that guarantee certain rights to women:

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, the doctor), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

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

Covered

- Normal deliveries (see "Required Pre-Authorizations" on page 14 for information on approvals necessary if you wish to receive unreduced benefits):
  - Semi-private room and board;
  - Special services and nursery charges;

  - Physician's services, including prenatal and post-natal care; and
  - Hospital charges for anesthesia (also covered when administered by a physician, other than the attending physician, who is not an employee of the hospital)
- Complications of pregnancy:
  - Treatment for any complications of pregnancy, including cesarean delivery;
  - Semi-private room and board (including nursery charges); and
  - Physician's services.
- Care of the newborn:
  - Nursery charges;
  - The initial examination of the well newborn by a physician, other than the mother's attending physician, and daily medical care during the routine stay of the mother; and
  - Circumcision of the newborn.

Benefits will be payable as they would for treatment of any other medical condition.

Certified Midwifery and Birthing Centers Benefit

Benefits are also available for the services of a midwife and birthing center as an alternative to the benefits described above.

After meeting the deductible, the Fund will pay 100% of the charges for services of a certified nurse midwife (no deductible), provided the expenses for such services would be reimbursed if they were performed by any other duly licensed practitioner. The Fund will also pay 100% of the charges when a birthing center is used in lieu of a hospital and the services or supplies would have been covered had treatment been rendered at a hospital.

"Certified nurse midwife" means a nurse midwife authorized to practice midwifery in the state in which such services are performed. The services provided must be within the lawful scope of practice for a certified nurse midwife.

"Birthing center" means a duly licensed facility that is equipped and operated solely to provide prenatal care, to perform uncomplicated spontaneous deliveries, and to provide immediate postpartum care. A birthing center must have all of the following:

- Staffing that includes direction by at least one physician specializing in obstetrics or gynecology, the presence of a physician or certified nurse midwife during each birth and immediate postpartum period, provision of full-time, skilled nursing services in the delivery rooms and recovery rooms (under the direction of a registered nurse or certified nurse midwife), and extension of staff privileges to physicians who provide obstetrical and gynecological care in an area hospital.

- A facility and equipment that includes at least two beds or birthing rooms for patients during labor and delivery, diagnostic x-ray and laboratory equipment (or a contract to use such equipment at an area medical facility), and equipment and supplies for administration of local anesthetic, for performing minor surgery, and for handling medical emergencies (including oxygen and resuscitation equipment, intravenous fluids and drugs to control the mother's bleeding, and drugs to assist the newborn in breathing).

- Policies and procedures by which the facility regularly charges patients for services and supplies, admits only patients with low risk pregnancies, contracts with an area hospital and displays written procedures for immediate transfer of mother and child in emergency cases, and has an on going quality assurance program with reviews by physicians, other than those who own or direct the facility.

Not Covered

- Genetic testing (except for amniocentesis, chorionic villus sampling, and alphafetoprotein analysis in pregnant women when found medically necessary by BlueCross BlueShield)

Special Infant Formula (up to 12 months of age)

Covered

- Non-prescription enteral infant formula for home use for which a physician has issued a written order and which is medically necessary for the treatment of one of the following conditions:
  - Malabsorption caused by Crohn's disease
  - Ulcerative colitis

– Gastroesophageal reflux
– Gastrointestinal motility
– Chronic intestinal pseudo-obstruction

The Fund will pay 70% of the charges, up to a maximum benefit of $1,000 per quarter and up to twelve months of age, provided a physician initially issues a written order identifying one of the five medical conditions previously listed and issues follow-up written orders for the infant formula every quarter.

Well Baby and Child Care

Covered

- Physical exams
- History
- Measurements
- Sensory screenings
- Development screening
- Hereditary and metabolic screening
- Immunizations
- Tuberculin tests
- Blood and urine tests

Benefits are payable in accordance with the Plan's Scheduled Benefits.

Treatment of Mental and Nervous Disorders

The Plan covers treatment of mental and nervous disorders that are pre-authorized by the Member Assistance Program (MAP). You must also use a MAP-approved facility or provider to receive the benefits below:

Covered

- Inpatient treatment: up to 25 days per calendar year.
- Partial Hospitalization Programs (PHP) or Intensive Outpatient Programs (IOP): up to 10 days per calendar year. PHP/IOP are programs that provide treatment in the outpatient setting of not less than three hours and not more than eight hours per day. If the cost of one session of partial hospitalization exceeds 50% of the cost of one day of inpatient care at the same hospital, such care will be considered inpatient care, subject to the same provisions and limits as care for any other illness.
- Adolescent Acute Residential Treatment (AART): up to 10 days per calendar year. For this benefit, adolescents are covered dependents from 13 up to 19 years of age.

  Adolescent Acute Residential Treatment means 24 hour psychiatric treatment in an unlocked setting for adolescents who require short-term clinically intensive psychiatric care. Treatment includes assessment, consultation, psychopharmacology, family therapy, treatment specialization, educational services and recommendations. Treatment teams collaborate with each patient, the patient's family, school, outpatient treatment programs and community agencies to promote a smooth transition back to the community.
- Outpatient treatment: up to 24 visits per calendar year, after you have used the eight visits per year available under the Member Assistance Program (see page 27).

Treatment of Alcoholism and Substance Abuse

The Plan covers treatment of alcoholism and substance abuse that is pre-authorized by the Member Assistance Program (MAP). You must use a MAP-approved facility to receive the benefits listed below:

- Inpatient admission for the treatment of substance abuse: up to 25 days per lifetime for detoxification and short-term rehabilitation. An initial inpatient admission for a maximum of 5 to 10 days must be pre-authorized by the MAP. A subsequent inpatient admission may be authorized only if you followed the aftercare plans recommended by the treating providers and the MAP. If aftercare plans are not followed, a subsequent short-term (maximum 3 days) inpatient admission may be authorized for detoxification only if it is determined to be necessary and appropriate by the MAP Case Manager. Initial and subsequent inpatient admissions will be subject to the days-per-lifetime limit specified above for detoxification and rehabilitation.
- Partial hospitalization: up to 10 days per calendar year. "Partial hospitalization" means continuous treatment of not less than three hours and not more than 12 hours per day. If the cost of one

session of partial hospitalization exceeds 50% of the cost of one day of inpatient care at the same hospital, such care will be considered inpatient care, subject to the same provisions and limits as care for any other illness.

- Outpatient treatment is available only after you have used the eight visits per calendar year available under the MAP (see page 27).
- Benefits for inpatient care will be paid the same as for any other illness, subject to the days-per-lifetime limit above for detoxification and rehabilitation.

Hospice Care

Hospice care benefits are available in the case of a patient who has a life expectancy of six months or less. The hospice coordinates inpatient and home care for the patient and the family as a unit. The hospice provides care to meet the special needs of the patient and the family during the final stages of terminal illness and during bereavement.

Covered

- Outpatient hospice care for services rendered on an outpatient basis in the home setting, as follows:
  - Part-time (intermittent) nursing care given in the home by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or licensed public health nurse
  - Hospice care or treatment visits by hospice staff personnel who are full-time employees of the hospice
  - Physical and respiratory therapy
  - Oxygen and equipment for the individual's care
  - The rental of wheelchairs and hospital-type beds and other medical equipment for the patient's care
  - Homemaker services
- Charges incurred for professional counseling sessions with the patient's family members during the period of hospice care
- Bereavement services for professional counseling sessions with the patient's family members for help in coping with the death of the patient within the three-month period following the patient's death

Care must be provided by a team of medical personnel, counselors, and other individuals who have had special training. It can include homemakers who work in conjunction with the hospice. The team must act with the purpose of helping the patient and the family cope with physical, social, psychological, and spiritual needs.

"Hospice" means a facility that operates as a unit of a program that admits only patients who do not have a reasonable prospect for a cure and who have a life expectancy of six months or less, as certified in writing by the attending physician. A hospice is separate from any other facility. However, it may be affiliated with a hospital, nursing home, or home health care agency. It must be approved as meeting the legal requirements, if any, of the state locality or authority having jurisdiction over licensing and approval.

Not Covered

- Hospice care or treatment that is not recommended or approved by a physician
- Hospice care or treatment for which there would have been no charge had there been no coverage
- Hospice care or treatment for any condition that is not payable under other provisions and benefits of this Fund
- Hospice care or treatment for any services rendered by a person who is a member of the patient's family or who ordinarily resides in the patient's home
- Hospice care or treatment for services for which benefits are not payable according to the "General Limits and Exclusions" on page 45

NETWORK PROVIDERS FOR HOME HEALTH CARE OR DURABLE MEDICAL EQUIPMENT

The PPO network for home health care or durable medical equipment is through BlueCross BlueShield. They can refer you to a network provider when you Call for the required pre-authorization.

Home Health Care

Home health care benefits are available for necessary services or supplies furnished in an individual's home in accordance with a home health

care plan. To be eligible for coverage, the home health care must start within seven days after release from a hospital confinement for the same or related condition. Each visit by a member of a home health care team will be considered one home health care visit. To receive the maximum benefits, be sure to contact BlueCross BlueShield for necessary pre-authorizations.

Covered

- Part-time or intermittent nursing care by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the supervision of an R.N., if the services of an R.N. are not available
- Part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature, by other than an R.N. or L.P.N.
- Physical therapy, occupational therapy and speech therapy
- Medical supplies, drugs, and medications prescribed by a physician and laboratory services by or on behalf of the home health care agency, to the extent such items would have been covered under this Fund if the patient had remained in the hospital

"Home health care plan" means a program:

- for continued care and treatment of the patient;
- certified and approved by BlueCross BlueShield;
- established and approved in writing by such patient's attending physician within seven days following termination of a hospital confinement as a resident inpatient;
- for treatment of the same or related condition for which the patient was hospitalized; and
- including certification in writing by a physician that the proper treatment of the illness or injury would require continued confinement as a resident inpatient in a hospital in the absence of the services and supplies provided as part of the home health care plan.

"Home health care agency" means an agency or organization that meets fully every one of the following requirements:

- it is primarily engaged in and duly licensed by the appropriate licensing authority to provide skilled nursing services and other therapeutic services (if such licensing is required);
- it has policies established by a professional group associated with the agency or organization (this professional group must include at least one physician and at least one registered nurse (R.N.) to govern the services provided, and it must provide for full-time supervision of such services by a physician or by an R.N.;
- it maintains a complete medical record on each patient; and
- it has a full-time administrator.

Durable Medical Equipment

Outpatient benefits are provided based on the allowed charge for durable medical equipment bought or rented by the member from an Appliance Company (or another provider who is designated by BlueCross BlueShield to furnish the specific covered appliance) for use in the home. These benefits are limited to equipment that: can stand repeated use; serves a medical purpose; is medically necessary for the member; is not useful if the member is not ill or injured; and can be used in the home.

Some examples of covered durable medical equipment include (but are not limited to):

- Hospital beds, wheelchairs, crutches, and walkers
- Glucometers which are medically necessary due to the patient's type of diabetic condition
- Bath seats
- Raised toilet seats
- Bed pans
- Motorized scooters, up to $2,500
- Oxygen

These benefits are limited to a dollar benefit maximum for each member in each calendar year. Refer to the Schedule of Eligible Medical Expenses for the amount of the benefit limit that applies for these covered services.

From time to time, the equipment that is covered by this Plan may change. This change will be based on BlueCross BlueShield's periodic review of medical policy and medical technology assessment guidelines to reflect new applications and technologies.

BlueCross BlueShield will decide whether to authorize the renting or buying of the durable

medical equipment. If BlueCross BlueShield decides that the equipment should be rented, benefits will not be more than the amount that would have been paid if the equipment were bought.

These benefits are provided for the least expensive equipment of its type that meets the member's needs. If BlueCross BlueShield determines that the member chose durable medical equipment that costs more than what the member needs for his or her medical condition, benefits are provided only for those charges that would have been paid for the least expensive equipment that meets the member's needs.

Hearing Care

The Plan provides coverage for hearing exam and device as follows:

Covered

- Provider services for examination and testing by a licensed physician or audiologist
- Hearing device prescribed by a physician or audiologist—one device per ear every five years to the day from original purchase

Other Medical Charges

Covered

- Expenses incurred from an attempt at suicide or a self-inflicted injury, including complications thereof.
- The services of a licensed physician, whether inpatient or outpatient.
- The services of a registered graduate nurse (R.N.) other than a nurse who ordinarily resides in your home or who is a member of your or your spouse's family.
- Emergency admission services: a complete history and physical exam of a patient who is admitted by a physician as an inpatient in an emergency, when treatment is immediately assumed by another physician.
- Intensive care services: services by a physician, other than the attending physician, to treat an unusual aspect or complication of an illness or injury.
- Services to interpret diagnostic x-rays and other imaging services and diagnostic laboratory services.
- Anesthesia and anesthesia services rendered by a physician, other than the operating surgeon or his/her assistant, who is not an employee of the hospital.
- Diagnostic admission services: when hospitalization for diagnostic purposes is necessary, the same hospital and physician benefits as described previously will be provided.
- Coverage in an outpatient department or emergency room or health center: charges for the following services provided in a hospital outpatient department or emergency room or in a community health center when necessary to diagnose or treat an illness or injury:
  - Surgery
  - Diagnostic x-rays and other imaging services
  - Diagnostic laboratory services
  - Hemodialysis treatment, equipment and supplies
  - Radiation therapy

Extension of Medical Benefits in Case of Disability

The Fund will continue to pay benefits for medical expenses for a specific illness or injury incurred on any day during the calendar year in which the covered individual who is disabled ceases to be covered under the Plan and during the next succeeding calendar year, provided that:

- the medical expenses incurred are in connection with an injury or illness for which the covered individual is totally disabled at the time he ceases to be covered;
- the covered individual is continuously so disabled to the date each medical expense is incurred; and
- you are not entitled to benefits for such medical expenses under any other group policy, whether issued by an insurance company or by any other insurer for benefits of a type similar to those provided here.

Filing a Claim for Medical Plan Benefits

Note: The discussion below applies to "post-service claims"—claims you submit after you have received a service. Requests for required pre-authorization are also considered claims. See "Required Pre-Authorizations" earlier in this chapter and "Claims and Appeals Procedures" on page 57 for more information on those types of claims.

PPO Providers

Any provider in the PPO network will be paid directly by BlueCross BlueShield. If you use a PPO provider, you are responsible for your deductible and copayment amounts.

Non-PPO Providers

To file a claim for benefits when you use a non-PPO provider you must submit a completed claim form to the Fund Office, unless your hospital, doctor, or other health care provider uses a standard billing form, such as a UB 92 or HCFA 1500, and files it directly with the Fund on your behalf.

If you have to file an inpatient and/or outpatient claim for substance/alcohol abuse, nervous/mental illness, or complementary care you must have the service pre-authorized by The Wellness Corporation prior to submitting the claim to the Fund Office.

You may obtain a health claim form from the Fund Office by calling 781-272-1000 or 800-342-3792, or from our Web site at www. MLBF.org.

All of the following information must be completed on the claim form that you get from your provider(s):

- Your name and Social Security number
- Your address
- Your date of birth
- Your marital status
- Information on other insurance coverage (if any)
- The patient's name and address and relationship to you
- The patient's date of birth
- The patient's sex
- The patient's student status
- If the condition is related to patient's employment or an accident, information on the employment or accident
- Date(s) of service
- Date the patient is able to return to work
- Date of total/partial disability
- Name of referring physician
- Hospitalization dates, if applicable
- CPT-4 (the code for physician services and other health care services found in the Current Procedural Terminology, Fourth Edition or later, as maintained and distributed by the American Medical Association)
- ICD-9 (the diagnosis code found in the International Classification of Diseases, 9th Edition or later, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services)
- Billed charge, amount paid, and balance due
- Signature of service provider
- Federal taxpayer identification number (TIN) of the provider
- Provider's billing name and address

Most accepted standard claim forms contain an assignment of benefits agreement, in the event you wish to assign your hospital or surgical benefits directly to the hospital or doctor. Upon receipt of the assignment agreement, the Fund Office will directly pay these benefits to your health care provider.

When Claims Must Be Filed

Claims must be filed within 90 days from the date the charges were incurred. If you have any questions about submitting your claim, contact the Fund Office.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims and Appeals Procedures" on page 57.

Prescription Drug Benefits

The Plan offers prescription drug coverage at retail pharmacies and through a mail-order program. This benefit is offered through Express Scripts.

FAST FACTS:

- You can walk into any participating retail pharmacy and have your prescription filled there. If you use a network pharmacy, you pay only your copayment at the time of purchase.
- Only the initial fill and two refills of the same prescription (three 30-day supplies) will be covered at the applicable copayment in the accompanying chart. Your copayment for any additional refills will be 50% of the cost.
- Prescriptions for drugs you take on a regular basis must be filled and refilled through the mail-order program, at a cost savings to you.
- The amount of your copayment will depend on whether your drug is a generic, a preferred brand-name, or a non-preferred brand-name. ("Preferred" means it is on the plan's preferred medication list.)
- Some drugs, for example, injectables, require pre-authorization.

The accompanying chart is intended to provide a convenient quick-reference guide to your prescription drug benefits. More detailed information follows the chart.

QUICK-REFERENCE GUIDE TO PRESCRIPTION DRUG BENEFITS FOR PLANS A AND B

Prescription filled at a retail pharmacy	You pay the following copayment per prescription for up to a 30-day supply: Generic drug: $5 Preferred brand-name: $15 Non-preferred brand-name: $25 The Fund covers the remaining cost. Note: Your copayment for any refills at a retail pharmacy beyond the third fill will be 50% of the cost.
Prescription filled through the plan's mail-order program	You pay the following copayment per prescription for up to a 90-day supply: Generic drug: $10 Preferred brand-name: $30 Non-preferred brand-name: $50 The Fund covers the remaining cost.

Use of Retail Pharmacies

Express Scripts has a network of participating retail pharmacies. Although you may have your prescription filled at either a participating or non-participating pharmacy, there are two good reasons for using a participating pharmacy:

- You won't have to worry about submitting a claim for reimbursement—you pay any copayment due at the time of purchase, and that's it. The pharmacy bills the Fund for the remaining cost.
- You'll save the Fund money and help it continue providing benefits because of the discounted prices negotiated with participating pharmacies.

If you use a participating retail pharmacy, simply present your Express Scripts identification card to the pharmacy and pay the applicable copayment from the accompanying chart.

If you use a non-participating pharmacy, you will have to pay the full amount billed at the time of purchase and submit a claim to Express Scripts. Express Scripts will reimburse you for the allowable amount, minus the applicable copayment.

Limit on Supplies from Retail Pharmacies

Only the initial fill and two refills of the same prescription (three 30-day supplies) will be covered at the applicable copayment in the accompanying chart. Your copayment for any additional refills will be 50% of the cost.

You are encouraged to use the mail-order program when you need a 90-day or more supply of a prescription drug.

PARTICIPATING PHARMACIES

To find a participating pharmacy, call Express Scripts at 800-467-2006 or visit the Web site at www.express-scripts.com.

Using the Mail-Order Program

If you use the mail-order program, you can get up to a 90-day supply for the same amount you would pay for two 30-day supplies at a retail pharmacy.

The mail-order program is a convenient way to obtain maintenance or long-term medication. You can obtain an Express Scripts envelope from the Fund Office or by calling Express Scripts. Fill in the requested information on the envelope, making sure you complete the allergy section if this is the first time you've ordered medication from Express Scripts. You need to enclose your physician's prescription and your copayment or credit card information.

You should receive your order within seven business days. You will receive another mailing envelope with your shipment. Please remember that reorders should be sent approximately two weeks prior to your medication running out. You may also order refills by phone at 800-233-7139 or online at www.express-scripts.com.

What the Plan Covers

Your prescription drug benefits cover all medications that by Federal law or state law require a prescription and are prescribed by a licensed practitioner (including new drugs approved by Express Scripts).

Included in your program is insulin by prescription and syringes and needles for injection of prescribed covered drugs, when ordered by a physician.

The Preferred Medication List

The Preferred Medication List is Express Scripts' list of preferred brand-name drugs.

This list includes drugs that are therapeutically equivalent to other drugs that are commonly prescribed by doctors for specified medical conditions. The doctors and pharmacists on the Express Scripts Pharmacy and Therapeutic Committee select the drugs on the list based on their appropriateness, clinical efficacy, and cost-effectiveness in the delivery of pharmaceutical care.

If you have questions about whether a drug is on the Preferred Medication List, you can call Express Scripts at 800-467-2006 or visit www.express-scripts.com.

Required Pre-Authorizations

Dispensing of certain drugs must be pre-authorized by Express Scripts.

To request pre-authorization, your doctor should call Express Scripts at 800-417-8164 or fax a letter of medical necessity to 800-357-9577. (These numbers are for physicians only.)

If you have questions about which drugs require pre-authorization, contact Express Scripts.

Requests for required pre-authorization are considered "pre-service claims." If you disagree with the decision made on your doctor's request for pre-authorization, you may appeal it. See the information on pre-service claims in "Claims and Appeals Procedures," starting on page 57.

Step Therapy Program

If you take prescription drugs regularly for certain conditions (like arthritis, asthma or high blood pressure, for example), the Step Therapy Program moves you along a path as outlined below—with your doctor approving the medications at each step.

First Step: Generic Drugs

This first step lets you begin, or continue, treatment with prescription drugs that have the lowest copayment. When you submit a prescription that is not for a first-step, generic drug, you or your pharmacist should contact your doctor. Only your doctor can approve and change your prescription to a first-step drug. You can call Express Scripts for examples of first-step, generic drugs to discuss with your doctor. Tested and approved by the U.S. Food & Drug Administration (FDA), generic drugs can be effective for treating many medical conditions.

Second Step: Brand-Name Drugs

If your path requires medications other than generic drugs, then the program moves you along to this

next step. If you have already tried a first-step, generic drug, or your doctor decides you need a different drug for medical reasons, then your doctor can call Express Scripts to request a "prior authorization" for a second-step drug. An Express Scripts agent will check your plan's guidelines to see if the second-step drug is covered. If it is covered, you pay the applicable copayment, which can be more than a first-step, generic drug. If it is not covered, you may need to pay the full price of the second-step drug.

Exclusions from Coverage

No benefits will be paid for the following:

- administration or injection of any medication
- drugs payable under Workers Compensation Law
- drugs required by federal and state mandates
- drugs administered in connection with motor vehicle accidents
- prescriptions for animals
- drugs prescribed during confinement in a hospital, rest home, sanitarium, extended care facility, skilled nursing facility, or convalescent hospital that operates on its premises a facility for dispensing pharmaceuticals (*see the "Medical Plan" chapter, starting on page 11, for information on benefits for drugs you receive while in the hospital*)

Filing a Claim for Prescription Drug Benefits

Note: The discussion below applies to "post-service claims"—claims you submit after you have had prescription filled or refilled. Requests for required pre-authorization are also considered claims. See "Required Pre-Authorizations" earlier in this chapter and "Claims and Appeals Procedures" on page 57 for more information on those types of claims.

You will not need to file a claim if you purchase prescription drugs in a participating retail pharmacy or use the mail-order program, since you will pay only your copayment.

You will need to file a claim for reimbursement if you have a prescription filled or refilled at a non-participating retail pharmacy. Contact Express Scripts for reimbursement forms.

When Claims Must Be Filed

Claims must be filed within 90 days from the date the charges were incurred.

If you have any questions about submitting your claim, contact Express Scripts.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims and Appeals Procedures" on page 57.

Frequently Asked Questions

Are contraceptives covered?

You have coverage for oral contraceptives when birth control pills are prescribed by a physician. Other forms of contraceptives are not covered.

Are erectile dysfunction drugs covered?

Erectile dysfunction drugs will be covered if your physician prescribes them as medically necessary and documents that you have been treated for male sexual dysfunction during the last six months.

If you wish to purchase erectile dysfunction drugs, call Express Scripts. Coverage is limited to six pills for each 30-day period.

What if my prescription costs less than the copayment?

If the cost is less than the copayment, you will pay only the cost.

Member Assistance Program

Problems such as family difficulties, marital stress, child and adolescent concerns, illness of a family member, financial pressure, job stress, or alcohol and drug abuse may disrupt your life and the lives of your loved ones.

To help you deal with such problems, the Trustees have contracted with The Wellness Corporation to provide the Member Assistance Program (MAP). It is designed to provide prompt, professional assistance for you and your eligible dependents when you are having personal and family difficulties or need treatment for mental health-related problems or substance abuse. The MAP is available under both Plan A and Plan B.

FAST FACTS:

- The Member Assistance Program can help you deal with life's problems.
- The Member Assistance Program works with the Fund's medical plan benefits for treatment of mental and nervous conditions or alcoholism and substance abuse.

The accompanying chart is intended to provide a convenient quick-reference guide to the Member Assistance Program.

QUICK-REFERENCE GUIDE TO THE MEMBER ASSISTANCE PROGRAM (MAP)

Calls to the Member Assistance Program	No charge.
Outpatient treatment for mental or nervous conditions or alcoholism or substance abuse	(If pre-authorized by MAP and you use the provider to which MAP refers you) Outpatient treatment beyond the first eight visits under the Member Assistant Program (MAP) and all inpatient treatment are handled under the medical plan—see page 19.

The Wellness Corporation is an organization of professionals who will provide you and your eligible dependents with confidential, professional assistance. Services are provided 24 hours per day, seven days per week. The Wellness Corporation's main objective is to direct you or your dependents as quickly as possible to the best available resource for help.

Required Pre-Authorizations

To receive any benefit payments from the Fund for any treatment of mental or nervous conditions or alcoholism or substance abuse, you must contact the Member Assistance Program before you or a dependent receives ANY treatment. When you call MAP, one of the MAP professionals will help you identify and evaluate your problems and, if necessary, refer you for treatment. If inpatient treatment is required, you will be referred to a MAP-approved facility and appropriate treatment plan.

The Member Assistance Program (MAP) Benefits are described on page 19.

REQUIREMENT TO CONTACT MAP

No benefits will be paid by the Fund if you fail to contact the Member Assistance Program before you or your dependents receive any inpatient or outpatient treatment for mental and nervous conditions or substance abuse.

Claims for Benefits

Claims for outpatient visits exceeding eight per year are handled under the medical plan. See page 19 for more information.

Dental Benefits

Your dental benefits are provided through Delta Dental of Massachusetts. Your eligibility for Plan A or Plan B is determined by the number of hours you worked during the previous 12-month Qualifying Period. See the "Eligibility" section for complete details.

Preventive care (exams, cleanings, etc.) is covered under Plan A and Plan B. Plan A also includes basic and major restorative care (from fillings to dentures) and orthodontia benefits for children under age 19. In addition, using a network provider can help you keep your share of the costs down.

The accompanying chart is intended to provide a convenient quick-reference guide to your dental benefits. Be sure to review the "What the Plan Covers" section for covered services and the limitations and restrictions of the Plan.

What the Plan Covers

The Fund pays benefits for the services shown in the accompanying chart, subject to the condition that the services be necessary and appropriate treatment. To be necessary and appropriate, a service must be:

- consistent with the prevention of oral disease or with the diagnosis and treatment of those teeth that are decayed or fractured or those teeth where the supporting periodontium is weakened by disease;
- in accordance with standards of good dental practice;
- not solely for the convenience of you or your dentist;
- not more costly than the services that are customarily provided (benefits will be based on the least costly method of treatment); and
- generally accepted as appropriate for treating your condition.

ELIGIBLE DENTAL EXPENSES

Provision	How It Works			
	Plan A		Plan B	
	PPO Provider	Non-PPO Provider in PPO Area	PPO Provider	Non-PPO Provider in a PPO Area
Annual deductible per calendar year	No deductible	No deductible	No deductible	No deductible
Diagnostic (Type I)	Fund pays 100%	Fund pays 100% of usual and customary charges	Fund pays 100%	Fund pays 100% of usual and customary charges
Preventive (Type I)	Fund pays 100%	Fund pays 100% of usual and customary charges	Fund pays 100%	Fund pays 100% of usual and customary charges
Restorative and Other Basic Services (Type II Services)	Fund pays 80%	Fund pays 80% of usual and customary charges	The Fund does not cover these services under Plan B. You are responsible for the full cost of the service.	
Major Restorative Services (Type III)	Fund pays 50%	Fund pays 50% of usual and customary charges	The Fund does not cover these services under Plan B. You are responsible for the full cost of the service.	
Other Dental Services				
Dental implants	Fund pays 50% of reasonable and customary charges, up to $2,500 per year and $5,000 per lifetime		The Fund does not cover these services under Plan B. You are responsible for the full cost of the service.	
Orthodontia	Lifetime maximum of $2,500. Available to age 19		The Fund does not cover these services under Plan B. You are responsible for the full cost of the service.	

Covered Services—Limits and Restrictions

Type I: Diagnostic and Preventive (Plan A and Plan B)

- Oral examinations (once every six months)
- Emergency exams (up to three times in 12 months)
- Full-mouth x-rays (once every 60 months)
- Bitewing x-rays (once ever 12 months for adults; once every six months for children under age 19)
- Single-tooth x-rays (as needed)
- Study models and casts and diagnostic casts (once every 60 months)
- Prophylaxis (cleaning) (twice per year)
- Fluoride treatment (once every six months for children under age 19)
- Space maintainers (for children under age 14)
- Pit and fissure sealants (limited to unrestored permanent molars; once every 48 months for children through age 15)

Type II: Restorative and Other Basic Services (Plan A only)

- Amalgam (metal) fillings (once every 24 months per surface per tooth)
- Composite (white) fillings (once every 24 months per surface per tooth on front teeth; single surface only on back teeth)
- Temporary fillings (once per tooth)
- Stainless steel crowns (once every 24 months for baby teeth only)
- Simple or surgical extractions, including impactions
- Periodontic scaling and root planing (once in 24 months) per quadrant
- Periodontal surgery not provided in a surgical day care nor hospital setting
- Periodontal prophylaxis (once every three months following active periodontal treatment)
- Root canal therapy (once per tooth)
- Pulpotomy (to age 14)
- Recementing of crowns, inlays, and onlays (once every 12 months per tooth)
- Rebase or reline of dentures (once every 36 months)
- Denture repairs (once every 12 months, same repair)
- Emergency palliative treatment (three occurrences in a 12-month period)

Type III: Major Restorative Services (Plan A only)

- Crowns, inlays, and onlays when teeth cannot be restored with regular fillings due to severe decay or fracture (once every 36 months per tooth)
- Complete or partial dentures once within 60 months, fixed bridges, and crowns when part of a bridge (once every 36 months)

DEVELOP GOOD DENTAL CARE HABITS

It's more cost-effective to maintain dental health than it is to regain it. Exercise proper dental hygiene and make use of the preventive services included in your dental benefits.

Participating Dentists

When you need dental care, you may choose a dentist participating in the network or a non-participating dentist. Choosing a participating dentist offers the following advantages:

- Participating dentists have agreed to accept fees determined by Delta Dental Plan. That means you will likely incur lower out-of-pocket costs than if you used a non-participating doctor.
- A participating dentist will file claims directly with Delta Dental. You need only pay the amount due from you when you receive your Explanation of Benefits and your dentist's bill.

PARTICIPATING DENTISTS

To find a participating dentist, call Delta Dental at 800-872-0500 or 617-886-1234 or visit the Web site www.deltamass.com.

Pre-Treatment Estimates

For most services, a dentist simply proceeds with treatment. However, in cases when the cost for the treatment is expected to be extensive, you are encouraged to have your dentist request a pre-treatment estimate. The result, which will be sent to both you and your dentist, will inform you of any estimated out-of-pocket expenses that you may incur before the services are performed.

You are encouraged to have your dentist submit a request for a pre-treatment estimate for any services that are likely to total $300 or more.

Exclusions from Coverage

The Fund will not pay benefits for the following:

- A method of dental treatment more costly than is customarily provided (benefits will be based on the least costly method)
- services that are meant primarily to change or improve your appearance
- replacement of lost or stolen appliances or artificial tooth replacements
- replacement of dentures more than once every three years or replacement of existing denture or bridgework installed for less than three years unless it is satisfactorily shown that the existing denture or bridgework cannot be made serviceable
- oral surgical or periodontal surgery benefits rendered in a surgical day care or hospital setting
- any professional fees other than the fees of the dentist performing the treatment
- services rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist
- services related to congenital anomalies
- charges that are not necessary, are not recommended and approved by the dentist, or are not reasonable and customary
- fees for treatment for an illness or injury arising out of or in the course of your employment
- fees that you are not required to pay or services for which you would be eligible for full or partial payment under any state, municipal, or Federal law or regulation
- expenses resulting from motor vehicle accidents
- expenses incurred after termination of your coverage, including expenses incurred for prosthetic devices inserted after the termination, regardless of whether or not the device was ordered before your coverage terminated
- repairing or recementing crowns and onlays once within 36 months per tooth
- services for temporomandibular joint syndrome (TMJ)
- coverage for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during performance of service in the uniformed services (*the uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities*).

Filing a Claim for Dental Benefits

Participating Dentists

If you use a participating dentist, you will not need to file a claim. Simply show your Delta Dental I.D. card when you visit your dentist, then pay the amount due from you when you receive your Explanation of Benefits and your dentist's bill.

Non-Participating Dentists

A non-participating dentist may or may not file a claim for you. If the dentist asks you to file the claim, you can download a form from the Web site www.deltamass.com or use a universal claim form. Your completed claim should be sent to the following address: Delta Dental Plan of Massachusetts, P.O. Box 9695, Boston, MA 02114.

If you use a non-participating dentist, you will be responsible for the dentist's full charge, minus the amount payable by the Fund.

When Claims Must Be Filed

Claims must be filed within 90 days of the date when you receive the service.

If benefits are denied because a participating dentist fails to submit a claim on time, you will not be responsible for paying the dentist for the portion of the dentist's charge that would have been a benefit under your plan. You will be responsible for the coinsurance amount or other patient liability, if any. This applies, however, only if you properly informed your participating dentist that you were a member by presenting your Subscriber ID Card.

If you have any questions about submitting your claim, contact Delta Dental.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims and Appeals Procedures" on page 57.

Vision Care Benefits

Your vision care benefits are provided through Davis Vision. You may obtain services from more than 100 participating providers throughout the New England area.

FAST FACTS:

- Under Plan A and Plan B, you and your eligible dependents are entitled to receive a comprehensive eye examination, new spectacle lenses, and an eyeglass frame once every 24 months.
- Also, under both plans children under age 19 will be eligible for these benefits once every 12 months.

RETIRED UNION MEMBERS

If you are a retired Maine, New Hampshire, Vermont, or Massachusetts Union member who maintains his Union membership, you and your eligible dependents are eligible for the vision care benefits described in this chapter. This benefit is maintained by the Massachusetts and Maine, New Hampshire and Vermont Laborers' District Councils, which have contracted with the Fund Office to provide this benefit.

How the Plan Works

You may use either a network or non-network provider for your vision care under Plan A and Plan B. If you use a network provider, you will not have to pay anything (*unless you order items that are not covered—see "Exclusions from Coverage" later in this chapter*). For both Plans, if you use a non-network provider, the benefits paid by the Fund will be limited to the reimbursement allowances described in this chapter under the "Optional Plan" section.

What the Plan Covers

Your vision care benefits cover an exam and eyeglasses and other services as shown in the following pages.

You may select two complete pairs of eyeglasses (one for near vision, one for distance vision) in lieu of receiving a bifocal.

Your benefit includes the following types of lenses at no extra cost:

- glass or plastic single vision, bifocal or trifocal lenses;
- oversize and over diopter (high power) lenses;
- PGX (photosensitive) glass lenses;
- glass grey #3 prescription sunglasses lenses;
- progressive addition lenses; and
- supershield coating for both single vision and multi-focal lenses.

Polycarbonate lenses will be provided to children and monocular patients without charge.

Using a Davis Vision Provider

If you select a Davis Vision provider, he or she will provide detailed information about the options to which you are entitled.

Call a Davis Vision doctor of your choice and schedule an appointment. Your doctor's office will determine your eligibility. If you would like to verify your eligibility for vision benefits prior to calling for an appointment, call 800-999-5431.

HOW TO FIND A DAVIS VISION PROVIDER

To locate the Davis Vision providers nearest you, call the automated Provider Locater System at 800-999-5431 or go to the Web site www.davisvision.com.

The Optional Plan

You may, if you prefer, go to a non-network optometrist, ophthalmologist, or optician to obtain your refraction examination and/or glasses.

If you choose a non-network optometrist, ophthalmologist or optician, you will be reimbursed up to the maximum allowance set forth in the following schedule of benefits:

SCHEDULE OF VISION CARE BENEFITS

Refraction and pathological examination by an optometrist, including the fitting of glasses and the verification of prescription lenses **Maximum**	$20.00	
Complete medical eye examination (exclusive of treatment), refraction, and pathological examinations by an ophthalmologist, including the fitting of glasses and the verification of prescription lenses **Maximum**	$30.00	
Frame (when prescription lenses are required) **Maximum**	$20.00	
Lenses:	**Single**	**Pair**
Single vision	$15.00	$30.00
Bifocal	$20.00	$40.00
Trifocal	$25.00	$50.00
(No benefits are allowed for Plano, non refractive lenses, contact lenses, or non-prescription sunglasses)		
Repair or replacement of broken or damaged frame or lenses, if it can be satisfactorily shown that the existing frame or lenses cannot be made serviceable:		
Frame	$10.00	
Lens or Lenses	as above	

Exclusions from Coverage

The Fund will not pay any benefits for the following:

- exams or materials provided more frequently than at the intervals specified in this chapter;
- medical or surgical treatment of the eye (*However, if the examination indicates the need for medical or surgical treatment, such care may be covered under the medical plan*);
- duplicate glasses, replacement of lost or broken glasses, such as prescribed or plain sunglasses, or for contact lenses, tinting, or types of lenses not listed above (All such items, if furnished, must be paid for by you); or
- services for which benefits are not payable according to the "General Limits and Exclusions" starting on page 45.

Filing a Claim for Vision Care Benefits

Davis Vision Providers

If you use a Davis Vision provider, you will not need to file a claim for benefits. If you order any items not covered (see "Exclusions from Coverage"), you will need to pay the cost of those items. Otherwise, your exam and eyeglasses will be covered in full.

Optional Plan Providers

If you use an optional plan provider, you will need to pay the provider in full and then file a claim form for the reimbursable amount. The Fund Office will send you a standard claim form to be filled out by you and the person(s) performing the services upon request. Reimbursements are sent to the member not the provider. Your completed claim form should be sent to Fund Office.

When Claims Must Be Filed

Claims must be filed within 90 days from the date the charges were incurred.

If you have any questions about submitting your claim, contact the Fund Office.

Weekly Accident and Sickness Benefits

The weekly accident and sickness benefits is for members only and it can help replace lost income when an injury or illness prevents you from working. This benefit provides the same level of coverage and is available under both Plan A and Plan B.

FAST FACTS:

- Weekly accident and sickness benefits are available only for disabilities that are not work-related or for which car insurance is compensating you for lost wages.
- Weekly accident and sickness benefits are available to eligible, active participants only—not to dependents.

Weekly Accident and Sickness Benefits	Provide you with a payment of up to $39 a day or $273 per week for up to 13 weeks. Benefits begin the 1st day for a disability caused by an accident or on the 8th day for a disability caused by illness.

Eligibility for Payment of Benefits

You will be eligible for the Plan's weekly accident and sickness benefits if, while covered under the Plan, you become totally disabled and unable to work because of

- any injury not arising out of or in the course of your employment;
- any disease not entitling you to benefits under any Workers' Compensation;
- occupational disease law, or similar legislation; or
- any injury or disease not entitling you to automobile insurance wage continuation payments.

It is not necessary to be confined to your home to collect benefits, but you must be under the care of a physician.

When Payment of Benefits Starts

Payment will start as of the first day of disability, if the disability is due to an accident, or the eighth day of the disability, if the disability is due to an illness.

No disability will be considered to have started until you have been treated personally by a physician.

Pregnancy-Related Disability

If you become totally disabled and medically unable to work because of pregnancy, childbirth, or miscarriage, weekly accident and sickness benefits are payable from the eighth day of disability on the same basis as any other illness.

How Long Payments Can Continue

You may receive weekly accident and sickness benefits for up to 13 weeks for any one continuous period of disability that is due to the same or related cause or causes, as long as you remain eligible. Successive periods of disability separated by less than two weeks of continuous active employment with an employer who makes contributions on your behalf to the Fund will be considered one continuous period of disability, unless they arise from different and unrelated causes, in which case a return to active work for at least one full day is required.

Limits and Exclusions

No benefits are payable for the following:

- any day you are not under the care of a physician,
- any day you are receiving compensation or performing work of any kind, anywhere, for compensation or profit,
- any day you are released by your physician to engage in work of any kind,
- a disability due to accidental bodily injuries arising out of and in the course of your employment,
- those days for which you are receiving compensation for lost wages from automobile insurance or its equivalent, Workers' Compensation, unemployment compensation, or any company sponsored pension plan, or
- services for which benefits are not payable according to the "General Limits and Exclusions" starting on page 45.

Filing a Claim for Weekly Accident and Sickness Benefits

You and your doctor must FULLY complete a Provider's Green Claim Form and return that completed form to the Fund Office.

When Claims Must Be Filed

Claims must be filed no later than 90 days after the date your disability began.

If you have any questions about submitting your claim, contact the Fund Office.

Life Insurance Benefits

In the event of your death from any cause—on the job or off—while you are covered under Plan A or Plan B, a death benefit of $10,000 will be paid to your named beneficiary.

FAST FACTS:

- The amount of the life insurance benefit is $10,000.
- Only eligible, active participants are eligible for life insurance coverage (not dependents).

Life Insurance Benefit	Pays your beneficiary $10,000 in the event of your death from any cause.

BENEFITS FOR RETIREES

If you are a retiree, see page 36 for information on the death benefit payable when an eligible retiree dies.

Your Beneficiary

Your beneficiary for this benefit is the designated beneficiary **that the Massachusetts Laborers' Health and Welfare Fund has on file for you for your health and welfare benefits**.

You may change your beneficiary at any time, provided you complete a Beneficiary Designation Form.

If you do not have a designated living beneficiary when you die, the insurance company and/or the Trustees will pay the proceeds of your life insurance to your estate.

If You Become Totally and Permanent Disabled

If you become totally and permanently disabled while eligible before you reach age 60, your life insurance coverage will be continued at no cost to you. You must complete and file an "Application for Total and Permanent Disability" with the Fund Office within 90 days of when the disability starts. Application forms are available at the Fund Office.

The insurance company will also require periodic proof that you continue to be totally and permanently disabled.

Extended Death Benefit

If you should die within 31 days from the date your insurance is terminated, the full amount of life insurance will be payable to your named beneficiary.

Conversion Privileges

Within 31 days following termination of your eligibility under the Plan, you may convert your group life insurance to an individual life insurance policy by mailing an application to The Union Labor Life Insurance Company.

To convert to an individual life insurance policy, contact the Union Labor Life Insurance Company at: 202-682-0900, 111 Massachusetts Avenue, N.W., Washington, D.C. 20001.

Since each participant is expected to know the eligibility rules of this Fund, and since it is not always possible for the Fund Office to send a notice of termination in sufficient time for a terminated participant to exercise the conversion privilege within the 31 day limit, each participant who desires to convert to an individual policy should, for his own protection, make it his personal responsibility to apply for conversion of the life insurance coverage within the 31 day period.

Filing a Claim for Life Insurance Benefits

In the event of your death, your beneficiary should contact the Fund Office to obtain a life insurance claim form. The completed claim form should be returned with any required documentation to the Fund Office.

Deadline for Submission

When submitting a claim, your beneficiary should allow time for the Fund Office to transmit the claim to the insurance company. Union Labor Life Insurance Company should receive notice of the claim within 90 days of the death or as soon thereafter as is reasonably possible.

If your beneficiary has any questions about submitting the claim, he or she should contact the Fund Office.

Accidental Death and Dismemberment Benefits (AD&D)

If you die as the result of an accident, your beneficiary may receive an additional death benefit. If you lose a limb or an eye, a benefit may be paid to you.

FAST FACTS:

- AD&D benefits are payable when an accident results in your death or causes you to lose an arm or leg or sight.
- Only eligible, active participants are eligible for AD&D benefits coverage (not dependents).
- AD&D benefits are paid in addition to any other benefits payable under the Plan.
- This benefit is available under both Plan A and Plan B.

AD&D BENEFITS

Description of Loss	Benefit Payable
Your death	$10,000 (Paid to your beneficiary or estate)
Loss of two of your limbs	$10,000 (Paid to you)
Loss of sight in both of your eyes	$10,000 (Paid to you)
Loss of one of your limbs and sight in one of your eyes	$10,000 (Paid to you)
Loss of one of your limbs	$5,000 (Paid to you)
Loss of sight in one of your eyes	$5,000 (Paid to you)
Loss of limb means dismemberment by severance at or above the wrist or ankle joint. Loss of sight means the entire and irrecoverable loss of sight.	

How the Benefits Work

AD&D benefits are payable as shown in the chart above for losses that are the direct result of bodily injuries sustained solely through accidental means while participants are insured under the Plan. They are payable whether or not the accident occurs during the course of your employment.

The loss must occur within 90 days from the day of the accident.

If you suffer more than one of the losses shown in the chart as the result of any one accident, no more than $10,000 will be payable.

Your Beneficiary

Your beneficiary for the accidental death benefit is the same beneficiary you have for your life insurance under the Massachusetts Laborers' Health and Welfare Fund.

You may change your beneficiary at any time, provided you notify the Fund Office and complete in writing the proper form.

If you do not have a designated beneficiary, the insurance company and/or the Trustees will pay the accidental death benefit (if applicable) to your estate.

Limits and Exclusions

No payment will be made for death or any loss resulting from or caused directly, wholly, or partly by:

- bodily or mental infirmity, ptomaines, bacterial infections (except infections caused by pyogenic organisms that occur with and through an accidental cut or wound), or disease or illness of any kind; or
- services for which benefits are not payable according to the "General Limits and Exclusions" starting on page 45.

Filing a Claim for Accident Death and Dismemberment (AD&D) Benefits

You or your beneficiary should contact the Fund Office to obtain an AD&D benefits claim form. The completed claim form should be returned with any required documentation to the Fund Office.

Deadline for Submission

When submitting a claim, please allow time for the Fund Office to transmit the claim to the insurance company. Union Labor Life Insurance Company should receive notice of the claim within 90 days of the loss or as soon thereafter as is reasonably possible.

If you or your beneficiary has any questions about submitting the claim, you should contact the Fund Office.

You may be eligible for continuing your medical and dental benefits after you retire. If you are a retired Union member and maintain your membership, you and your dependents are covered under the vision benefit provided by the Massachusetts Laborers' District Council and the Maine, New Hampshire and Vermont District Council.

FAST FACTS:

- You can continue medical and dental coverage for yourself and your eligible dependents by making payments to the Fund Office. The Fund Office shares in the cost for retiree coverage.
- If you were enrolled in Plan A COBRA coverage, you may elect Plan A retiree self-pay coverage.
- If you were enrolled in Plan B COBRA coverage, you may elect Plan B retiree self-pay coverage.
- Your beneficiary may receive a death benefit when you die.

The Retiree's Self-Pay Medical Program

Eligibility

You may continue your medical and dental coverage under the Massachusetts Laborers' Health and Welfare Fund if:

- you have been continuing coverage at your own cost under COBRA (see page 5);
- you are receiving a Pension from the Massachusetts Laborers' Pension Fund;
- you make an election to enroll in the Retirees' Self-Pay Medical Program; and
- you are not eligible for Medicare.

Who Can Be Covered

You may elect to cover yourself and your eligible dependents. Only those who are COBRA participants can be covered under the Retirees' Self-Pay Medical Plan.

If you elect to cover yourself only at the time you elect to enroll in the Retiree Self-Pay Medical Program, you will not be allowed to later cover your dependents.

ELIGIBLE DEPENDENTS

See page 3 for information on who is an eligible dependent under the Plan.

What Benefits Are Included

You may be eligible for medical or medical and dental coverage as follows:

- Plan A retiree self-pay plan if you were enrolled in Plan A COBRA
- Plan B retiree self-pay plan if you were enrolled in Plan B COBRA

You will not be eligible for weekly accident and sickness benefits, life insurance, accidental death and dismemberment, or vision benefits regardless of which plan of benefits you elect.

How Long Coverage Will Last

Coverage under the Retirees' Self-Pay Medical Plan will terminate on the **earliest** of the following dates:

- when timely payment is not made;
- when a covered individual becomes eligible for Medicare; or
- (*for dependent children*) when the child no longer meets the definition of a dependent under the Health and Welfare Plan.

Retiree Vision Care & Hearing Benefits

You and your eligible dependents may participate in the vision and hearing programs if you are a retired member of a construction local of the Massachusetts Laborers' District Council who maintains his or her Union membership with the Laborers' International Union of North America; and made dues contributions through your working dues into the retiree benefit account maintained by the Massachusetts Laborers' District Council.

Retired members and their eligible dependents in the Maine, New Hampshire and Vermont construction locals who maintain their Union membership will also be eligible for vision benefits only.

Retiree Death Benefit

To be eligible for the retiree death benefit, you must:

- be retired from the labor market, as that term is defined under the rules and regulations of the Massachusetts Laborers' Pension Plan; and
- have been covered by the Fund for three out of the last five years prior to date of your retirement.

The amount of the retiree death benefit is $3,000. This amount will be paid to your beneficiary in the event of your death.

This chapter provides information on what to do if you experience an event that might involve your benefits.

FAST FACTS:

The following life events may involve your benefits:

- Getting married
- Adding a child to your family
- Divorcing or legally separating from your spouse
- A child's losing eligibility for benefits
- Serving in the military
- Taking a medical or family leave
- Moving
- Becoming disabled
- Terminating your employment
- Retiring
- Death

If You Get Married

If you get married, you may add your new spouse to your health care coverage. You may also want to designate your new spouse as your beneficiary for your life insurance and Accidental Death and Dismemberment (AD&D) benefits.

☑ CHECKLIST

- ✓ Contact the Fund Office within 30 days of your marriage to add your new dependent(s) to your health care coverage. Failing to notify the Fund Office within 30 days of your remarriage will result in you being responsible to reimburse the Fund for any payments made on behalf of that dependent.
- ✓ Send the Fund Office an official copy of your marriage certificate and an official copy of your spouse's birth certificate.
- ✓ If you wish to designate your new spouse as beneficiary for your life insurance and AD&D benefits, request a beneficiary designation form from the Fund Office or visit the Web site at www.MLBF.org.

If You Add a Child to Your Family

You may add any eligible dependent children to your health care coverage. You may also want to designate a new child as beneficiary or one of your beneficiaries for your life insurance and AD&D benefits.

☑ CHECKLIST

- ✓ Contact the Fund Office within 30 days of the date you wish to add a child to your health care coverage.
- ✓ Provide the Fund Office with a copy of the child's birth certificate (long form).
- ✓ If you wish to change your beneficiary designation for your life insurance and AD&D benefits, request a beneficiary designation form from the Fund Office or visit the Web site at www.MLBF.org.

If You Divorce or Legally Separate from Your Spouse

Your ex-spouse may be eligible for continuation coverage under the conditions described on page 8.

☑ CHECKLIST

- ✓ Contact the Fund Office within 30 days to have your spouse removed from your benefits coverage, if applicable.
- ✓ Send the Fund Office a copy of your court decree with agreements.
- ✓ Update your beneficiary information as necessary.
- ✓ If your ex-spouse's address has changed because of the divorce or separation, please inform the Fund Office in writing of the new address.

If a Child Loses Eligibility for Coverage

Coverage for a child who ceases to be an eligible dependent will end when that child attains the age of 19 or 23 if a full-time student. Your child may continue health care coverage under COBRA for up to 36 months.

CHECKLIST

- ✓ If the child wishes to continue benefits coverage under the Fund, he or she may do so by electing COBRA continuation coverage. It's your responsibility to notify the Fund Office if you wish to continue coverage through COBRA. See page 5 for more information about COBRA.
- ✓ The Fund Office will send COBRA information to the address it has on file for you. If your child resides at another address, you are responsible for getting the COBRA information to him or her.

If You Enter Military Service

If you enter active military service in the uniformed services of the United States while eligible for Fund coverage, you and your eligible dependents can continue to be covered as long as your eligibility continues.

CHECKLIST

- ✓ Submit a copy of your military induction and separation orders or DD Form 214 to the Fund Office upon entering/ending active military service.
- ✓ Make sure you adhere to the provisions for returning to covered employment after your military service ends.

If You Move

The Fund Office sends notices by mail of updates to procedures, eligibility, explanation of benefits and other important matters relating to the Plan. These notices are sent to the address that's on file at the Fund Office.

CHECKLIST

- ✓ If you move, it is your responsibility to let the Fund Office know in writing about your change of address or update your address in the Member Dashboard on the Web site at www.MLBF.org.

If You Become Disabled

If you are unable to work because of a disability that is not work-related and for which you will not receive car insurance wage continuation payments, you may be eligible for weekly accident and sickness benefits (replacement income of up to $273 per week for up to 13 weeks). See page 33 for more information.

The Plan also has two other provisions that may be of interest to you:

- The Fund may continue to pay medical benefits for the disability even after you lose eligibility for benefits coverage under the Plan (see page 22);
- If you become totally and permanently disabled before you reach age 60, your life insurance coverage may be continued at no cost to you (see page 34).

CHECKLIST

- ✓ If you think you have a disability that qualifies for weekly accident and sickness benefits, contact the Fund Office regarding applying for benefits.
- ✓ If you are disabled and choose extended benefits for a particular illness (see page 22), you may lose your rights to elect COBRA.
- ✓ If you are interested in continuing your life insurance coverage at no cost to you, complete and file an "Application for Total and Permanent Disability" with the Fund Office within 90 days of when the disability starts. Application forms are available at the Fund Office.

If Your Eligibility Ends

When your eligibility ends, you and your eligible dependents may continue your health care coverage for up to 18 months (29 months if the Social Security Administration finds one of you disabled) under COBRA.

- After COBRA ends, you may continue health care coverage under the Retirees' Self-Pay Medical Program, if you qualify.

If you wish, you may convert your life insurance to an individual policy.

CHECKLIST

✓ To continue your health care coverage under the Fund, you must enroll in COBRA continuation coverage within 60 days of when notice of your COBRA rights arrives from the Fund Office or the date your coverage would otherwise end, whichever is later. See page 5 for more information about COBRA.

✓ If you wish to convert your life insurance to an individual policy, you must apply directly to the insurance company within 31 days of when your eligibility for coverage under the Fund terminates. See page 34 for more information about conversion to an individual policy.

In the Event of Your Death

In the event of your death, your eligible dependents may continue their health care coverage for up to 36 months under COBRA. Your beneficiary will be eligible for the proceeds of your life insurance coverage and, if your death was the result of an accident, the accidental death benefit included in your AD&D benefits.

CHECKLIST

✓ To continue their health care coverage under the Fund, your dependents must enroll in COBRA continuation coverage within 60 days of when notice of your COBRA rights arrives from the Fund Office or the date your coverage would otherwise end, whichever is later. (The COBRA information will be sent to the address on file for you, so they should notify the Fund Office if it needs to be sent to a different address.) More information about COBRA can be found starting on page 5.

✓ Your beneficiary should contact the Fund Office to find out how to apply for the life insurance benefit and, if applicable, the accidental death benefit.

Coordination of Benefits

Coordination of health care benefits conserves your health care dollars and protects the entire Plan from unnecessary increases in cost.

FAST FACTS:

- Coordination of Benefits prevents duplicate benefit payments when a person is covered under more than one plan.
- Rules for order of payment determine which plan pays first.

Quite frequently, because both husband and wife are working, members of a family could be covered under more than one plan of group health care benefits. There are many instances of duplication of coverage—for example, two plans paying benefits for hospital and medical expenses. For that reason a Coordination of Benefits provision has been adopted that will coordinate the health care benefits payable by the Plan with similar benefits payable under other plans.

How Coordination of Benefits Works

Under the Coordination of Benefits provision, if you or any of your dependents is also insured or entitled to health coverage under any other group plan, the total payment received for any one person from all such programs combined may not amount to more than 100% of the "allowable expenses."

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

Benefits are reduced only to the extent necessary to prevent an individual from recovering more money than he was charged and required to pay.

PRESUMPTION OF OTHER COVERAGE

If other coverage is available, this Plan will coordinate its benefits with that coverage even if you or your spouse fails to accept the other coverage.

For purposes of Coordination of Benefits, the word "plan" means any of the following plans that provide full or partial health benefits for services on an insured or self funded basis:

- any group practice plans, HMO or prepayment plans;
- union welfare plans, employer organization plans, or labor management trustee plans;
- governmental programs or coverages required or provided by law (other than governmental program coverage that is not allowed by law to coordinate); and
- Medicare, title XVII of the Social Security Act of 1965, as amended, to the extent permitted by law.

"Plan" will apply separately to each policy, contract, agreement, or other plan for benefits or services. It will also apply separately to that part of such a policy, contract, agreement, or plan that reserves the right to consider the benefits or services of other plans in determining its benefits and that part which does not.

Which Plan Pays First

The plan under which benefits are payable first is the primary plan. All other plans are called secondary plans. The secondary plans pay any remaining unpaid allowable expenses. No plan pays more than it would have paid without this provision.

The rules below determine which plan's benefits are payable first:

- A plan that does not have a Coordination of Benefits provision is always primary and pays first.
- If an individual is covered as a participant under two plans, the plan that has covered him the longer is primary.

- A plan that covers the individual as an active participant pays before a plan that covers the individual as a laid off member or as a retiree.
- A plan that covers the individual as a participant pays before a plan that covers the individual as a dependent.

The rules to determine which plan's benefits are payable first when a dependent child is covered under two or more plans are as follows:

- If the parents are not divorced or separated, the plan that covers the parent whose date of birth occurs earlier in the calendar year, excluding year of birth, pays first. If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period of time pays first.
- If the individual is a dependent child of separated or divorced parents, the "order of payment" used to determine the primary plan is as follows:
  - The plan of the natural parent with custody of the child pays first.
  - If a court order makes one parent financially responsible for the health care expenses of the child, that parent's plan will pay first.

If you or any of your eligible dependents elect to be covered by an employer-sponsored Health Maintenance Organization that is determined to be the primary payer, no benefits are payable under this Plan. Also, if you or any of your eligible dependents violate the provisions of the Health Maintenance Organization (e.g. neglect to utilize the facilities of the HMO), no benefits will be payable under this Plan.

Finally, if the Fund Office has made payment of any amount that is in excess of that permitted by these Coordination of Benefits rules, the Fund Office has the right to recover such amount from any party that has received such overpayment.

DUTY TO REPORT OTHER COVERAGE

You are required to report any other group health coverage that covers you or an eligible dependent on any claim submitted to the Fund Office.

Coordination with Other Funds Under Reciprocal Arrangements

If you are entitled to benefits under more than one Laborers' Fund in New England without combining the hours from each, the fund having the earliest eligibility will be primary and the other fund will be secondary.

Coordination with Medicare

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

If you or your dependent are covered by this Plan and by Medicare and you retain your coverage under this Plan, your health care coverage will continue to provide the same benefits as long as you have Plan eligibility, with this Plan paying first and Medicare paying second.

If you become totally disabled and entitled to Medicare while you have Plan eligibility, this Plan pays first and Medicare pays second. If you become totally disabled and entitled to Medicare, you will no longer be considered to have Plan eligibility if you are receiving coverage under this Plan through COBRA continuation coverage or retiree health coverage, and Medicare will pay first and this Plan will pay second. Generally, if an eligible dependent under this Plan becomes totally disabled and entitled to Medicare, for that eligible dependent this Plan pays first and Medicare pays second.

If, while you have Plan eligibility, you or any of your covered dependents becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan will pay first and Medicare will pay second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare will pay first and this Plan will pay second.

Reimbursement and Subrogation

Third-Party Liability

The Plan does not cover, nor is the Fund liable for, any health expenses incurred by you or an eligible dependent as a result of an accident or injury for which one or more third parties are or may be legally liable. You or one of your eligible dependents may incur medical expenses in a situation where a third party—for example, Workers' Compensation, the driver of an automobile, or an auto insurance or other liability carrier—may be liable or held responsible for their payment. At their discretion, the Trustees may pay some or all of the health expenses even where a third party liability may exist. In this situation, the Fund has all rights of recovery that you or your dependents would have, including the right to bring suit in your or your dependents' name.

You and your dependents must cooperate with the Fund to secure the recovery of the payment. You and your dependents will give no release or discharge with respect to any rights of recovery and will do nothing to prejudice those rights without the written consent of the Fund. If you or your dependents recover any amounts from the third party or its insurer, the Fund must be reimbursed from the recovery for benefits that it has paid.

Before the Fund will pay benefits for expenses that may be the responsibility of a third party, you, your attorney and your dependents will be required to sign an agreement affirming the obligation to reimburse the Fund from the proceeds of any recovery. The obligation to reimburse the Fund, however, does not depend on whether a reimbursement agreement actually is signed. By accepting the payment of benefits, you and your dependents agree to comply with all of the Fund's reimbursement policies and acknowledge its subrogation and lien rights.

The Fund will withhold payment on any claim when it believes that a third party may be responsible until a reimbursement agreement is executed. You, your attorney and your dependents must execute the reimbursement agreement and submit it for receipt by the Fund Office within 90 days of the date of the accident or injury. If it is not reasonably possible to submit the executed reimbursement agreement within 90 days, it must be received by the Fund Office as soon as reasonably possible but in no event later than one year from the date of the accident or injury. If you or your dependents fail to comply with this obligation to sign and submit the reimbursement agreement within the deadline, the Fund will deny all claims relating to the accident or injury. The Fund will further seek reimbursement of any claims paid relative to this accident or injury.

If you or your dependent asserts a claim of any nature concerning an injury or condition for which the Fund has paid or may pay benefits, the Fund must be promptly notified of all the details. If you or your dependent retains an attorney in connection with an injury or condition for which the Fund has paid or may pay benefits, the attorney must be promptly notified of the Fund's subrogation and reimbursement policies and provided with a copy of the reimbursement agreement, and the Fund must be promptly notified of the attorney's name and address. The attorney will not distribute any amounts subject to reimbursement or any disputed amounts, but will hold them in a client trust account until all disputes are finally resolved and the Fund is reimbursed.

The Fund has an equitable lien on that portion of any recovery from a third party that you or your dependents are obligated to reimburse, and that lien right will have first priority over any other lien or claim against the recovery. The Fund's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds

or assets. In addition, that portion of a recovery from a third party that you or your dependents are obligated to reimburse is and will be considered to be an asset of the Fund as of the moment the recovery is transferred by the third party, whether or not it is actually received by the Fund, and title to that portion will vest immediately in the Fund.

You, your dependents and those acting on your or their behalf including attorneys will be fiduciaries to the Fund with respect to the portion of any recovery that is subject to reimbursement until it is actually received by the Fund. You, your dependents, and those acting on your or their behalf will hold such portion of any recovery in constructive trust for the benefit of the Fund, will place and maintain such portion of any recovery or any disputed portion of the recovery in a separate segregated account until your or your dependents' reimbursement and fiduciary obligations to the Fund are satisfied, and will immediately notify the Fund of the location and account number of any account in which the portion of the recovery that is subject to reimbursement is deposited or transferred.

If you or a dependent fails to comply with any of the Fund's reimbursement or subrogation policies, the Fund may deny all claims concerning the underlying injury or condition. If you or a dependent fails to reimburse the Fund or to pay the Fund's costs, expenses and attorneys fees incurred in litigation, the Fund may withhold payment of future benefits from you as well as from all of your dependents, regardless of whether or not the benefits are related to the underlying injury or condition, up to the amount due plus interest, as well as the amount of any costs, expenses, and attorneys fees. The Fund may withhold future benefits regardless of whether the Fund has sought judicial enforcement of its rights.

Subrogation

If you or your dependent is involved in an automobile or any motor vehicle accident covered by an insurance policy, the insurance carrier will initially be liable for lost wages, medical, surgical, hospital, and related charges and expenses up to the greater of the maximum amount of basic benefit required by applicable law or the maximum amount of the applicable insurance coverage in effect. Thereafter, the Plan will consider any excess charges and expenses under the applicable provisions of the respective Plan in which you are provided coverage. The Fund will have the right to bring suit in the name of you or your dependents against any party that may be liable for the sums paid by the Fund for medical benefits.

You or your dependents exclusively may bring suit against any liable party within seven months of the date of injury for which benefits are paid. After seven months have elapsed from the date of injury for which benefits have been paid, the Fund may also bring suit in the name of you or your dependents.

For any recovery obtained by you or your dependent, the Fund's share of the recovery, whether through suit or settlement, will be determined based on the following method:

First, you or your dependent's reasonable attorney's fees (not to exceed 33% of the total recovery) will be deducted from the total recovery.

If the Total Adjusted Recovery is:	Then the Fund's Share of Recovery is:
1. Equal or less than the benefits paid by the Fund	50% of the benefits paid by the Fund
2. Greater than the benefits paid by the Fund, but less than twice or equal to twice the benefits paid by the Fund	75% of the benefits paid by the Fund
3. Greater than twice the benefits paid by the Fund	100% of the benefits paid by the Fund

Any amounts remaining thereafter will be paid to you or your dependent.

You and your dependents must execute instruments and papers, furnish information, provide assistance and take all other necessary and related action as the Fund may request to facilitate satisfaction of its subrogation as well as its reimbursement and lien rights.

Upon the Fund's request, you, your attorney and your dependents will execute an assignment of your and their rights under any uninsured/underinsured portion of any automobile liability insurance policy in order to satisfy an obligation to reimburse the Fund and satisfy the Fund's subrogation and lien rights as described above.

Qualified Medical Child Support Orders (QMCSOs)

This section describes the Qualified Medical Child Support Orders (QMCSOs) under which the Plan may be directed to enroll a dependent child of yours in coverage.

A QMCSO is any court judgment, decree, or order (including the approval of a settlement agreement) that creates or recognizes an alternate recipient, such as a child or stepchild, to be eligible under this Plan. As required by ERISA, the Plan will recognize a QMCSO that:

- provides for child support of child(ren) under the Plan;
- provides for health coverage to child(ren) under state domestic relations law; (including a community property law); and
- relates to benefits under this Plan.

To qualify, a QMCSO must include the names and mailing addresses of you and each alternate recipient covered by the order. It must also provide a reasonable description of the type of coverage to be provided and specify the name of the plan and the period to which the order applies.

A QMCSO may not require the Plan to provide any type or form of benefits or option which it does not otherwise provide, except as necessary to meet certain requirements of the Social Security Act relating to the enforcement of state child support laws and reimbursement of Medicaid.

Once the Fund Office receives a QMCSO, it will promptly notify you and each alternate recipient named in the order in writing, including a copy of the order and of the Plan's procedures for determining whether the order qualifies as a QMCSO. The Fund Office will also allow the alternate recipients to designate representatives to receive copies of notices sent to them. Finally, the Fund Office will determine within a reasonable time whether the order qualifies, notify the appropriate parties of the determination, and ensure that the alternate recipients are treated as beneficiaries under ERISA reporting and disclosure requirements.

Coverage under a QMCSO will start on the date specified in the order.

If you would like a copy of the Plan's procedures for handling Qualified Medical Child Support Orders, please contact the Fund Office. A copy will be provided free of charge.

General Limits and Exclusions

In addition to any limits or specific exclusions included in the chapters on different benefits earlier in this booklet, there are general limits and exclusions that apply to all benefits. No payment will be made for expenses incurred for you or any one of your eligible dependents for the following:

- Services, supplies, or treatments that are not prescribed, recommended, or approved as medically necessary. This exclusion also applies to any hospital confinement or any part of a confinement;
- fees that are in excess of the reasonable and customary charges for services, supplies, or treatment;
- cosmetic surgery, unless required because of:
  - an accidental bodily injury provided treatment occurs within one year from the date of the accident; or
  - reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection, or other disease of the involved part; or
  - reconstructive surgery, when required because of a congenital disease or anomaly of a dependent child that has resulted in a functional defect; or
  - reconstructive surgery following a mastectomy.
- services or supplies not listed as covered charges;
- expenses incurred as a result of participation in a felony, riot, or insurrection;
- meals, meal preparation, personal comfort or convenience items, housekeeping services, custodial care, and protective or companion services;
- any services rendered by a physician or any other provider of medical services to himself;
- any expenses related to transsexual surgery;
- an injury or an illness that is employment related or that is or could be covered under the Workers' Compensation Law, occupational disease law, or similar laws;
- where a claim/appeal for Workers' Compensation is settled by stipulation or agreement, you cannot claim benefits for the same disability from the Fund. If benefits are paid in error, the Fund must be reimbursed for any payments to you or your dependents or providers and all costs of collection, including attorney's fees and court costs;
- expenses incurred during confinement in a hospital owned or operated by the Federal government, unless required by law;
- any charges that you or your dependent are not legally required to pay, including charges that would not have been made if no coverage existed;
- charges for custodial care, which are institutional services and supplies, including room and board, that are designed primarily to assist the individual in the activities of daily living, rather than connected to a medical program that can be expected to improve the individual's medical condition;
- charges that are not received at the Fund Office, along with all required supporting information necessary to process the claim, within 90 days from date they were incurred;
- loss caused by war or any act of war;
- to the extent that you or your dependent is in any fashion paid or entitled to payment for those expenses by or through a public program;
- experimental drugs or substances not approved by the Food and Drug Administration or drugs labeled: "Caution limited by Federal law to investigational use;" or non-FDA approved for that specific purpose;

- experimental procedures or treatment methods not approved by the American Medical Association, the American Dental Association, or the appropriate medical or dental specialty society;
- services, treatments, or supplies furnished by or at the direction of the United States government, any state or other political subdivision thereof, or any of its agents or agencies;
- charges from injuries that occur as a result of engagement in inherently dangerous activities, such as automobile racing, motorcycle racing or other motorized racing equipment, bungee jumping, boxing or wrestling for profit, etc.;
- to the extent of the exclusions imposed by BlueCross BlueShield for certain elective surgical procedure and hospital and extended care facility admissions;
- infertility benefits;
- early intervention services; and
- coverage for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during performance of service in the uniformed services (*the uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities*).

In addition, benefits otherwise payable upon injury to you or your eligible dependent shall be denied for any injury that results from your or your dependent's operation of a motor vehicle while under the influence of alcohol or narcotic drugs, as defined by state law. Benefits will also be denied under this provision when the affected automobile insurance carrier providing motor vehicle insurance or medical benefits denies coverage for injuries due to the operation of a motor vehicle while the person is under the influence of alcohol or narcotic drugs. Benefits will also be denied for any injury to you or your eligible dependent when you or the dependent is operating an uninsured and/or stolen motor vehicle. Benefits shall not be denied for passengers in the motor vehicle who are otherwise eligible for benefits and who are injured.

Plan Facts

The chart below provides a fast reference for administrative information about the Health and Welfare Plan.

Legal Name of the Plan	Massachusetts Laborers' Health and Welfare Fund
Plan Number	501
Employer Identification Number	04-2214296
Plan Type	A Qualified Employee Health and Welfare Benefit Plan that provides medical care, life insurance and accidental death and dismemberment benefits to eligible employees and their qualified dependents.
Fiscal Year	July 1 — June 30
Plan Administrator	The Board of Trustees 14 New England Executive Park Suite 200 P.O. Box 4000 Burlington, MA 01803-0900 Telephone: 781-272-1000 Toll-Free Telephone: 800-342-3792 Fax: 781-272-2226 Online: www.MLBF.org
Agent for Service of Legal Process	Service of legal process may be made upon any Fund Trustee.
Type of Administration of the Plan	Fully funded, self-insured Fund, governed by the Employee Retirement Income Security Act (ERISA) of 1974. collectively bargained, jointly-trusteed labor management trust.
Sources of Financing	Payments made to the trust by individual employers under the provisions of the Collective Bargaining or Participation Agreements, participant self-pay contributions, and any income earned from investment of employer and participant self-pay contributions. Participants and beneficiaries may receive from the Fund Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Fund and, if the employer or employee organization is a Fund sponsor, the sponsor's address. All monies are used exclusively for providing benefits to eligible participants and their dependents, and the paying of all expenses incurred with respect to the operation of the Plan. The Trustees shall review annually the funding status of the Plan.

The Board of Trustees

The Board of Trustees is made up of an equal number of Employer Representatives and Union Representatives who serve without compensation.

Discretionary Authority of the Board of Trustees and its Designees

In carrying out their respective responsibilities under the Plan, the Board of Trustees, the Fund Administrator and other individuals with delegated responsibility for the administration of the Plan will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Plan Amendment and Termination

The Board of Trustees reserves the right to terminate or amend the Plan including the right to amend or terminate benefits or eligibility for any class of participant, when in their sole discretion they determine such action is in the best interest of the Fund and its participants. In addition, the

Plan may be terminated by the Trustees if there is no longer an agreement in effect between the Employers and the Union requiring contributions to the Health Fund.

Should the Plan terminate, the Trustees will apply remaining assets of the Fund to continue benefits beyond the date of termination. The Trustees reserve the right to amend the eligibility rules at the time of termination. In any case, the Trustees will use any remaining assets of the Fund to provide benefits and pay administration expenses or otherwise to carry out the purpose of the Plan in accordance with the Plan Document and Trust Agreement until the entire remainder of the Fund has been disbursed.

Collective Bargaining Agreements/ Employer Contributions

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

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

Organizations Through Which Benefits Are Provided

The benefits shown in the following chart are fully insured.

FULLY INSURED BENEFITS

Benefit	Identity of Provider
Life insurance, and accidental death and dismemberment insurance	Union Labor Life Insurance Company

The benefits described in the following chart are paid directly by the Fund itself, or through providers with which the Fund has contracted, pursuant to administrative services agreements, and are not fully insured. Payment of benefits is not guaranteed by the Fund, nor does the provider insure or guarantee any of the benefits described.

ADMINISTRATIVE SERVICES FOR BENEFITS PAID DIRECTLY BY THE FUND

Area of Administration	Identity of Provider
Preferred Provider Organization for providers in the medical plan	BlueCross BlueShield Locate a Provider: 800-810-2583 www.BCBS.com
Professional review organization for the medical plan and Preferred Provider Organization for home health care and durable medical equipment	BlueCross BlueShield Hospital Admission: 800-327-6716 Locate a Provider: 800-810-2583 www.BCBS.com
Professional review organization and Preferred Provider Organization for treatment of mental health or nervous disorders, alcoholism, and substance abuse	The Wellness Corporation (MAP) 800-522-6763
Preferred Provider Organization for the dental plan	Delta Dental Plan of Massachusetts 800-872-0500 www.deltamass.com
Professional review organization and Preferred Provider Organization for prescription drug benefits	Express Scripts 800-467-2006 www.express-scripts.com
Preferred Provider Organization for the vision plan	Davis Vision 800-999-5431 www.davisvision.com

No Liability for Practice of Medicine

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

Your ERISA Rights

As a participant in the Massachusetts Laborers' Health and 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 are entitled to the following rights:

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These documents include insurance contracts and collective bargaining agreements and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements and copies of the latest annual report and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under a group health plan, if you have creditable coverage from another plan. You should be provided a HIPAA certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or 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 employee benefit plans. 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 it 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 which 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. However, in all cases, including those described in the above paragraph, you must first exhaust your administrative remedies by following the Claims and Appeals Procedures described in Appendix B before you may file suit in any court.

Assistance With Your Questions

If you have any questions about your plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory. Alternatively, you may obtain assistance by calling EBSA toll-free at 866-444-EBSA (3272) or writing to the following address:

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 obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA at 800-998-7542 or contacting the EBSA field office nearest you.

You may also find answers to your plan questions and a list of EBSA field offices at the website www.dol.gov/ebsa.

Appendix A: Privacy of Health Information

A Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the privacy of your personal health information be protected.

The Plan's Privacy Notice, distributed to all Plan participants and dependents, explains what information is considered "Protected Health Information (PHI)." It also tells you when the Plan may use or disclose this information, when your permission or written authorization is required, how you can get access to your information, and what actions you can take regarding your information.

PRIVACY NOTICE

Section 1: Purpose of This Notice and Effective Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice applies to the Fund Office of the Massachusetts Laborers' Health and Welfare Fund (the "Fund"), and the services that the Fund provides through BlueCross BlueShield of Massachusetts, Delta Dental, Express Scripts (formerly known as NPA/CFI), Davis Vision and other business associates of the Fund.

Effective date: The effective date of this Notice is April 14, 2003.

This Notice is required by law. The Fund is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Fund's uses and disclosures of Protected Health Information (PHI),
2. Your rights to privacy with respect to your PHI,
3. The Fund's duties with respect to your PHI,
4. Your right to file a complaint with the Fund and with the Secretary of the United States Department of Health and Human Services (HHS), and
5. The person or office you should contact for further information about the Fund's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

When the Fund May Disclose Your PHI

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:

- ***For treatment, payment or health care operations.*** The Fund and its business associates will use PHI in order to carry out:
  1. Treatment,
  2. Payment, or
  3. 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 surgeon the name of your treating physician so that the surgeon may ask for necessary health information.
- ***Payment*** includes but is not limited to actions 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 preauthorizations).
- 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."
- ***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 program, 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 Board of Trustees of the Massachusetts Laborers' Health and Welfare Fund, for purposes related to treatment, payment, and health care operations, and has amended the Summary Plan Description to permit this use and disclosure as required by federal law. For example, we may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.
- In addition, the Fund may disclose "summary health information" to the Board of Trustees for obtaining premium bids or modifying, amending or terminating the Fund's group health plan. Summary information summarizes the claims history, claims expenses or type of claims experience by individuals for whom a Plan Sponsor such as the Board of Trustees has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with federal privacy rules.
- ***At your request.*** 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.
- ***When required by applicable law.***
- ***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.
- ***Public health purposes.*** To an authorized public health authority if required 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.
- ***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.
- ***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 health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).

- ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.
- ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).
- ***Law enforcement emergency purposes.*** For certain law enforcement purposes, including:
  1. identifying or locating a suspect, fugitive, material witness or missing person, and
  2. disclosing information about an individual who is or is suspected to be a victim of a crime.
- ***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. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.
- ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.
- ***Research.*** For research, subject to certain conditions.
- ***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.
- ***Workers' Compensation programs.*** When authorized by and to the extent necessary to comply with Workers' Compensation or other similar programs established by law.

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.

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.

The Fund may provide health information for the purpose of evaluating and processing a claim for Accident and Sickness benefits; however, the Fund will obtain your written authorization before it will use or disclose any health information for this purpose.

When You Can Object and Prevent the Fund from Using or Disclosing PHI

Disclosure of your PHI to family members, other relatives, your close personal friends, and any other person you choose is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Other Uses or Disclosures

The Fund may contact you to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Section 3: Your Individual Privacy Rights

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to:

Privacy Official
Massachusetts Laborers' Health and Welfare Fund
14 New England Executive Park, Suite 200
Burlington, MA 01803
(781) 272-1000 or (800) 342-3792

You May Request Confidential Communications

The Fund will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Fund's Privacy Official (at the address listed above).

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains the PHI.

The Fund must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. A reasonable fee may be charged. Requests for access to PHI should be made to the Fund's Privacy Official (at the address listed at the left).

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Fund and HHS.

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.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Fund's Right to Amend Policy (available on request from the Fund's Privacy Official) for a list of exceptions.

The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with

the denial and have that statement included with any future disclosures of that PHI.

You should make your request to amend PHI to the Fund's Privacy Official (at the address listed on page 54). You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of certain disclosures by the Fund of your PHI. We do not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. See the Fund's Accounting for Disclosure Policy (available on request from the Fund's Privacy Official) for the complete list of disclosures for which an accounting is not required.

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.

If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Fund's Privacy Official (at the address listed on page 54).

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 you having to complete an Appointment of Personal Representative form. For example, the Fund will automatically consider a spouse, a parent of a member, or an adult child (age 18 or over) of a member to be the personal representative of an individual covered by the plan. In addition, the Fund will consider a parent or guardian as the personal representative of a dependent covered child, unless applicable law requires otherwise. A spouse, parent or adult child may act on an individual's behalf, including requesting access to their PHI. Spouses and 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.

You should also review the Fund's Policy and Procedure for the Recognition of Personal Representatives (available upon request from the Fund's Privacy Official) for a more complete description of the circumstances where the Fund will automatically consider an individual to be a personal representative for purposes of exercising your rights under this Privacy Notice.

Section 4: The Fund's Duties

Maintaining Your Privacy

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This notice is effective beginning on April 14, 2003 and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed,

a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI.

The Privacy Notice will be provided via first class mail to all named participants. Any other person, including dependents of named participants, may receive a copy upon request.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to:

1. The uses or disclosures of PHI,
2. Your individual rights,
3. The duties of the Fund, or
4. Other privacy practices stated in this notice.

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:

1. Disclosures to or requests by a health care provider for treatment,
2. Uses or disclosures made to you,
3. Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
4. Uses or disclosures required by law, and
5. Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

1. Does not identify you, and
2. With respect to which there is no reasonable basis to believe that the information can be used to identify you.

Section 5: Your Right to File a Complaint with the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the following Privacy Official (at the address listed above).

You may also file a complaint with:

Secretary of the U.S. Department
of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

The Fund will not retaliate against you for filing a complaint.

Section 6: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at the Fund Office.

Section 7: Conclusion

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

Appendix B: Claims and Appeals Procedures

This section describes the procedures for filing claims for benefits from the Massachusetts Laborers' Health and Welfare Fund. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

Discussed below are the various types of claims associated with Plan benefits, procedures for filing claims, and the steps involved in appealing a decision with which you disagree. The processing times mentioned in the discussion are summarized in the charts at the end of the discussion.

Use of an Authorized Representative

An authorized representative, such as your spouse, may complete a claim form for you if you are unable to complete the form yourself and have designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

A health care professional with knowledge of your medical condition may act as an authorized representative in connection with the "urgent care claims" discussed below without your having to designate an authorized representative.

Types of Claims

There are six types of claims applicable to the benefits described in this section. Four of them have to do with health care:

- **Pre-service claims:** A pre-service claim is a request for authorization of care or treatment that requires approval in whole or in part before the care or treatment is obtained (also called "pre-authorization" or "pre-certification").

  Under this Plan, prior approval of services is required for the following:
  - non-emergency hospital admissions, other than stays of a certain length following childbirth, or admission to a skilled nursing facility;
  - surgery;
  - gastric bypass surgery;
  - complementary medical care (biofeedback, homeopathy, massage therapy, naturopathy, nutrition, oriental medicine);
  - hospice or home health care;
  - inpatient or outpatient treatment for a mental or nervous condition, alcoholism, or substance abuse;
  - durable medical equipment; and
  - certain prescription drugs (see page 25 for information on how to obtain a list of drugs that require pre-authorization).

  If you fail to get prior approval for these services, **penalties could range from $250 (for an inpatient admission) to complete denial of the claim (for all other services requiring pre-authorizations).**

- **Urgent care claims:** Your request for a required pre-authorization will be considered an urgent care claim if applying the time frames allowed for a pre-service claim (*generally 15 to 30 days for a request submitted with sufficient information*) would:
  - seriously jeopardize your life or health or your ability to regain maximum function; or
  - in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

  The claims examiner, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, will determine whether your claim is an urgent claim. Alternatively, if a physician with knowledge of your medical condition determines your claim is an urgent claim and notifies the claims examiner in writing, it will be treated as an urgent claim.

- **Concurrent claim:** A concurrent claim is a decision that is reconsidered after an initial

approval was made, resulting in a reduction, termination, or extension of the previously approved benefit. (For example, an inpatient hospital stay originally pre-approved for five days is subjected to concurrent review at three days to determine if the full five days are appropriate.) In this situation, a decision to reduce, terminate, or extend treatment is made concurrently with the provision of treatment. This category also includes requests by you or your provider to extend care or treatment approved under an urgent claim.

- **Post-service claims:** Any other type of health care claim is considered a post-service claim—for example, a claim submitted for payment after health services and treatment have been obtained.

The other two types of benefit claims under this Plan are as follows:

- **Disability claim:** A disability claim is a claim for weekly accident and sickness benefits or a claim that requires a finding that you are totally disabled (for example, to receive the disability extension described on page 22).
- **Claims for life insurance and accidental death and dismemberment benefits** (*called "life and AD&D claims" in the text that follows*).

Urgent care claims should not be confused with emergency care or treatment at an urgent care facility, which do not require pre-authorization. An urgent care claim is a request for a required pre-authorization (a "pre-service claim") that needs to be handled on an expedited basis.

What is NOT a "Claim"

The following are not considered claims and are thus not subject to the requirements and time frames described in this section:

- Casual inquiries about benefits or the circumstances under which benefits might be paid;
- A request for an advance determination regarding the Plan's coverage of a treatment or service that does not require pre-authorization (such as the recommended requests for pre-treatment estimates for dental services); and
- A prescription you present to a pharmacy to be filled.

Filing a Claim

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. The method used to file a claim will depend on the type of claim:

- **Pre-service claims:**
  - **Pre-service claims for medical services other than treatment of a mental or nervous condition, alcoholism, or substance abuse:** You or your doctor should call BlueCross BlueShield at 800-327-6716.
  - **Pre-service claims for treatment a mental or nervous condition, alcoholism, or substance abuse:** Call the Member Assistance Program (MAP) at 800-522-6763.
  - **Pre-service claims for prescription drug benefits:** Your doctor should call Express Scripts at 800-417-8164 or fax a letter of medical necessity to 800-357-9577.
- **Urgent care claims:** Urgent claims (claims for pre-authorization that need to be handled on an expedited basis) should be directed to the same parties mentioned above for pre-service claims.
- **Post-service claims:** Claim forms for post-service health care claims must be completed in full, and an itemized bill or bills must be attached.

  Post-service health care claims for medical and vision care benefits (necessary if you use a non-network provider) should be sent to the Fund Office at the following address: Massachusetts Laborers' Health and Welfare Fund, 14 New England Executive Park, Suite 200, P.O. Box 4000, Burlington, MA 01803-0900. You can obtain a claim form from the Fund Office; alternatively, your hospital, doctor, or other health care provider may use a standard billing form, such as a UB 92 or HCFA 1500, and file it directly with the Fund on your behalf. For specific information on filling out claim forms for medical plan benefits, see page 23.

  Claims for prescription drug benefits (a claim for reimbursement if you use a non-network pharmacy) should be submitted directly to

Express Scripts, P.O. Box 390873, Bloomington, MN 55439-0873. Forms are available from Express Scripts or the Fund Office.

Claims for dental benefits (necessary if you use a non-network dentist) should be sent to Delta Dental Plan of Massachusetts, P.O. Box 9695, Boston, MA 02114. You can download a claim form from the Web site www.deltamass.com or use a universal claim form.

- **Disability, life and AD&D claims:** Disability claims and life and AD&D claims should be sent to the Fund Office at the following address: Massachusetts Laborers' Health and Welfare Fund, 14 New England Executive Park, Suite 200, P.O. Box 4000, Burlington, MA 01803-0900. The Fund Office will forward claims for life and AD&D benefits to the insurance company.

When Claims Must Be Filed

Your claim will be considered to have been filed on the first business day it is received by the applicable claims evaluator mentioned under "Filing a Claim."

Pre-service and urgent claims must be filed **before services are obtained**.

Dental claims must be filed within one year of the date when you receive the service. You must submit all other health care claims **within 90 days** of when expenses are incurred (or, it that is not reasonably possible, no later than one year after charges were incurred).

Claims for disability benefits must be submitted **within 90 days** of the onset of disability.

Claims for life and AD&D benefits must be filed **within 90 days** of the loss.

Notification That Your Pre-Service or Urgent Claim Has Not Been Properly Filed

An example of an improperly filed claim is one that is not addressed to a person or organizational unit customarily responsible for handling benefit matters.

If your **pre-service** claim has been improperly filed, you will be notified as soon as possible but no later than **five days** after receipt of the claim of the proper procedures to be followed in filing a claim.

If your **urgent care** claim has been improperly filed, you will be notified as soon as possible but no later than **24 hours** after receipt of the claim of the proper procedures to be followed in filing a claim.

You will receive notice that you have improperly filed your claim only if the claim includes your name, your specific condition or symptom, and a specific treatment, service, or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

Timing of Initial Claims Decisions

A determination on your claim will be made within the following time frames:

- **Pre-service claims:** If your pre-service health care claim has been properly filed, you will be notified of a decision within **15 days** from the date your claim is filed, unless additional time is needed. The time for response may be extended by up to **15 days** if necessary due to matters beyond the control of the applicable claims evaluator. If an extension is necessary, you will be notified before the end of the initial **15-day** period of the circumstances requiring the extension and the date by which the claims evaluator expects to make a decision.

  If an extension is needed because the claims evaluator needs additional information from you, the claims evaluator will notify you as soon as possible, but no later than **15 days** after receipt of the claim, of the specific information necessary to complete the claim. In that case you and/or your doctor will have **45 days** from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either the **45 days** have passed or you respond to the request (whichever is earlier). The claims evaluator then has **15 days** to make a decision and notify you of the

determination. If the information is not provided within the 45 days allowed, your claim will be denied.

- **Urgent care claim:** You will be notified of a determination by telephone as soon as possible, taking into account the exigencies of your situation, but no later than **72 hours** after receipt of the claim by the claims evaluator. The determination will also be confirmed in writing.

  If your urgent care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the claims evaluator will notify you as soon as possible, but no later than **24 hours** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must respond to this request within **48 hours**. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either the two business days have passed or you respond to the request (whichever is earlier). Notice of a decision will be provided no later than **48 hours** after the receipt of the required information. If the information is not provided within the two business days allowed, your claim will be denied.

- **Concurrent claim:** A reconsideration that involves the termination or reduction of payment for a treatment in progress (other than by Plan amendment or termination) will be made by the claims evaluator as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

  A request by you to extend treatment approved under an urgent claim will be acted upon by the claims evaluator within 24 hours of receipt of the claim, provided the claim is received at least **24 hours** prior to the expiration of the approved treatment.

- **Post-service claims:** Ordinarily, you will be notified of the decision on your post-service health care claim within **30 days** of the date the claims evaluator receives the claim. This period may be extended one time by up to **15 days** if the extension is necessary due to matters beyond the control of the claims evaluator. If an extension is necessary, you will be notified before the end of the initial **30-day** period of the circumstances requiring the extension and the date by which the claims evaluator expects to make a decision.

  If an extension is needed because the claims evaluator needs additional information from you, the claims evaluator will notify you as soon as possible, but no later than **30 days** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor or dentist will have **45 days** from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier). The claims evaluator then has **15 days** to make a decision on your post-service claim and notify you of the determination. If the information is not provided within the 45 days allowed, your claim will be denied.

- **Disability claims:** The Fund Office will ordinarily make a decision on the claim and notify you of the decision within **45 days** of receipt of the claim. This period may be extended by up to **30 days** if the extension is necessary due to matters beyond the control of the Fund Office. If an extension is necessary, you will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Fund Office expects to make a decision. A decision will then be made within **30 days** of when the Fund Office notifies you of the delay. The period for making a decision may be extended an additional **30 days**, provided the Fund Office notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund Office expects to render a decision. The notification of the extension

will specifically provide an explanation of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed from you to resolve the issues.

If an extension is needed because the Fund Office needs additional information from you, the Fund Office will notify you as soon as possible, but no later than **45 days** after receipt of the claim, of the specific information necessary to complete the claim. You will have **45 days** from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either **45 days** have passed or the date you respond to the request (whichever is earlier). The Fund Office then has **30 days** to make a decision on your claim and notify you of the determination. If the information is not provided within the **45 days** allowed, your claim will be denied.

For disability claims, the Plan reserves the right to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

- **Life and AD&D claims:** The insurance company will ordinarily make a decision on a claim for life or AD&D benefits within **90 days** of when it receives the claim. This period may be extended by up to **90 days** if the extension is necessary due to matters beyond the control of the insurance company. If an extension is necessary, you will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date by which the insurance company expects to make a decision.

Notice of a Denied Claim

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will include:

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

Appeal Process for Denied Claims

Information on appeals for dental benefits is omitted from the discussion that follows. For dental claims, you must exhaust the appeals process with Delta Dental first. (See the brochure from Delta Dental.) You may then file a voluntary appeal with the Plan's Board of Trustees.

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review (appeal the decision).

You must submit your appeal to the Fund Office by the applicable deadline.

- within **180 days** after you receive the notice of denial for a claim involving health care or disability (or, in the case of a concurrent claim,

within a reasonable time, given the exigencies of your situation); or

- within **60 days** after you receive the notice of denial for life and AD&D claims.

Requests for review of claims other than urgent care claims must be in writing. Appeals involving urgent care claims may be made orally by calling the Fund Office at 781-272-1000 or 800-342-3792 during normal business hours.

The appeal process works as follows:

Pre-Service, Urgent Care, and Concurrent Claim Appeals

For pre-service, urgent care, and concurrent claim appeals, there is one level of appeal. A subcommittee consisting of the Union Trustee Chairman or his or her alternate, the Employer Trustee Secretary-Treasurer or his or her alternate, and the Fund Administrator will review pre-service, urgent care, and concurrent claim appeals. In certain circumstances such as urgent care claim appeals where medical conditions exist that require an expedited review process, appeals may be made orally via telephone.

Post-Service and Disability Claim Appeals

For post-service and disability claims appeals, there is a two-level appeal process. The first level of appeal will consist of a review by the Fund Administrator. If the appeal is denied, you have the right to a second level consisting of review by the full Board of Trustees. Requests for second-level appeals must be made within 60 days after the first appeal is denied.

Life Insurance and AD&D Claim Appeals

For life insurance and AD&D claim appeals, there is one level of appeal at the Fund Office. The Fund Office will review the claim appeal.

Information To Which You Are Entitled

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon in making the decision); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, who gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim or the previous appeal. The reviewer will not give deference to the previous adverse benefit determinations. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

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

Timing of Notice of Decision on Appeal

- **Pre-Service Claims:** You will be sent a notice of decision on review within **30 days** of receipt of the appeal by the Fund Office.
- **Urgent Care Claims:** You will be notified of a decision on your appeal, either orally or in writing (or both) within **72 hours** of receipt of the appeal by the Fund Office.
- **Post-Service Claims:** For first-level appeals, a decision will be made on the appeal within **30 days** of receipt of the appeal by the Fund Administrator. For second level appeals, decisions will be made at the next regularly scheduled **meeting of the Board of Trustees** following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting,

your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, the Fund Office will give you written notice of the decision as soon as possible, but no later than five days after the decision has been reached.

- **Disability Claims:** For first-level disability claim appeals a decision will be made by the Fund Administrator within **45 days** of receipt of the appeal at the Fund Office. If the Fund Administrator determines that special circumstances require an extension of time, then you will receive a written notice of the extension before the end of the 45-day period. The notice will include the reasons required for the extension and the approximate date the Plan expects to make a decision.

  For second level appeals, decisions will be made at the next regularly scheduled **meeting of the Board of Trustees** following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, the Fund Office will give you written notice of the decision as soon as possible, but no later than five days after the decision has been reached.

- **Life and AD&D claims:** Decisions will ordinarily be made within **60 days** of receipt of appeal by the Fund Administrator. The period for making a decision may be extended by up to **60 days**, provided the Fund Administrator notifies you, prior to the expiration of the first **60 days**, of the circumstances requiring the extension and the date as of which the Fund Administrator expects to render a decision.

Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon by the Plan, either a statement that you will receive either a copy of the rule or a statement that it is available upon request at no charge;
- If the determination was based on medical necessity, the treatment's being experimental or investigational, or other similar exclusion, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim or a statement that it is available upon request at no charge.

Limitation on When a Lawsuit May be Started

You may not start a lawsuit to obtain benefits until after you have:

- exhausted all levels of appeal and final decisions have been reached on those appeals; or
- the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision.

The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them.

No lawsuit to recover Plan benefits may be started more than 15 months after the date of loss (that is, the date you incurred the expense you are seeking to have the Plan pay) upon which the lawsuit is based.

Because the Plan grants its fiduciaries discretionary authority to determine eligibility for benefits and to construe the terms of the Plan, the issue in a lawsuit will be limited to whether or not the Board of Trustees (or its delegates, including the subcommittee for Urgent Care, Pre-Service and Concurrent Claims) acted arbitrarily or capriciously in making its determination.

MAXIMUM TIMES FOR PROCESSING OF HEALTH CARE CLAIMS

(Times are suspended during waits for additional information requested of you)

	Pre-Service Claims	Urgent Claims	Concurrent Claims	Post-Service Claims
Claims examiner makes initial determination (provided all necessary information is submitted)	Within 15 days of claim's receipt (can be extended for another 15 days)	Within 72 hours of claim's receipt	In time for you to appeal before a reduction or termination Within 24 hours of request for extension of urgent care	Within 30 days of claim's receipt (can be extended for another 15 days)
Claims examiner notifies you claim has been improperly filed	Within five days of claim's receipt	Within 24 hours of claim's receipt	Not applicable	Not applicable
Claims examiner requests additional information	Within 15 days of claim's receipt	Within 24 hours of claim's receipt	Not applicable	Within 30 days of claim's receipt
You respond to request for information	Within 45 days of request	Within 48 hours of request	Not applicable	Within 45 days of request
Claims examiner makes determination after requesting additional information	Within 15 days of your response or expiration of the time allowed	Within 48 hours of your response or expiration of the time allowed	Not applicable	Within 15 days of your response or expiration of the time allowed
You make request for appeal	Within 180 days of receiving notice of denial	Within 180 days of receiving notice of denial	Within a reasonable time for your situation	Within 180 days of receiving notice of denial
Appropriate authority makes decision on appeal	Within 30 days of receiving your request for appeal	Within 72 hours of receiving your request for appeal	Within a reasonable time for type of care decision	First level: Within 30 days of receiving your request for appeal Second level: At next regular Board meeting at least 30 days after receiving your request for appeal (or no later than third such meeting)

MAXIMUM TIMES FOR PROCESSING OF DISABILITY AND LIFE AND AD&D CLAIMS

(Times are suspended during waits for additional information requested of you)

	Disability Claims	Life and AD&D Claims
Fund Office or insurance company makes initial determination (provided all necessary information is submitted)	Within 45 days of claim's receipt (can be extended for another 30 days and an additional 30 days after that)	Within 90 days of claim's receipt (can be extended for another 90 days)
Fund Office requests additional information	Within 45 days of claim's receipt	Not applicable
You respond to request for information	Within 45 days of request	Not applicable
Fund Office makes determination after requesting additional information	Within 30 days of your response or expiration of the time allowed	Not applicable
You make request for appeal	Within 180 days of receiving notice of denial	Within 60 days of receiving notice of denial
Board of Trustees makes decision on appeal	First level: Within 45 days of receiving notice of denial (can be extended) Second level: At next regular Board meeting at least 30 days after receiving your request for appeal (or no later than third such meeting)	Within 60 days of receipt of your request for appeal (can be extended another 60 days)

Appendix C: Glossary

These are some of the terms used in your booklet. Some other terms are described where they are used. Please read these terms carefully. They may help you to better understand your benefits.

Ambulatory Surgical Facility means any public or private establishment that:

- is licensed as such by the state,
- has an organized medical staff of physicians,
- has permanent facilities,
- is equipped and operated primarily for the purpose of performing surgical procedures, and
- provides continuous physician and registered graduate nursing services, whenever a patient is in the facility.

Ambulatory surgical facility does not include physicians' or dentists' offices or any facilities whose primary purpose is the termination of pregnancy or a facility that provides services or other accommodations for patients to stay overnight.

Complications of Pregnancy means:

- conditions requiring hospital stays when the pregnancy is not terminated and the diagnosis is distinct from pregnancy but is adversely affected by pregnancy or caused by pregnancy; or
- non-elective cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Covered Medical Expenses means the reasonable and customary charges that are incurred for the medically necessary treatment of conditions that are covered under this Plan.

Custodial Care means all services and supplies, including room and board, that are provided, whether you are disabled or not, primarily to assist in the activities of daily living. Such services and supplies are custodial care without regard to the practitioner or provider by whom or by which they are prescribed, recommended, or performed. Some examples of such services are: help in walking, getting in and out of bed, bathing, dressing, eating, taking medicine.

Dentist means a person authorized by law and duly licensed to practice dentistry.

Experimental procedure means:

- any medical procedure, equipment, treatment or course of treatment, or drug or medicine that is meant to investigate and is limited to research, or is not approved by a sanctioning body, i.e., Federal Drug Administration, American Medical Association, or American Dental Association;
- techniques that are restricted to use at centers that are capable of carrying out disciplined clinical efforts and scientific studies;
- procedures that are not proven in an objective way to have therapeutic value or benefit; and
- any procedure or treatment whose effectiveness is medically questionable.

Extended Care Facility means an institution, or a distinct part of an institution, that

- is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, skilled nursing care for patients who require medical care on account of Injury or sickness;
- provides 24 hour a day nursing service under the supervision of a full-time employee who is either a doctor or a registered nurse;
- maintains clinical records on all patients;
- provides for having a physician available to furnish necessary medical care in case of emergency; and
- provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals.

In no event, will "extended care facility" include any institution that is a hospital or that is primarily for the care of mental illness, drug addiction, alcoholism, or tuberculosis or that is primarily engaged in providing domiciliary, custodial, or educational care or care for the aged. Benefits are payable under the hospital plan provision.

Hospital means an institution that:

- is primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services for the diagnosis, treatment, and rehabilitation of injured, disabled, or sick persons;
- maintains clinical records on all patients;

- has bylaws in effect with respect to its staff of physicians;
- has a requirement that every patient be under the care of a physician;
- provides a 24 hour nursing service rendered or supervised by a registered professional nurse;
- is licensed pursuant to any state or agency of the state responsible for licensing hospitals; and
- has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

Unless specifically provided, the term “hospital” does not include any institution, or part thereof, that is used principally as a rest facility, nursing facility, convalescent facility, or facility for the aged, nor does it mean any institution that makes a charge that you or your dependents are not required to pay. Licensed institutions used principally for the care and treatment of mental and nervous disorders or alcoholism and substance abuse will be included under the definition of “hospital.”

Illness means any sickness, disorder, or disease that is not employment related. Pregnancy is treated in the same manner as an illness under this Plan for you or an eligible dependent.

Injury means physical damage to your or your dependent’s body caused by purely accidental means, independent of all other causes. Only injuries that are not employment related except as provided on page 45 or automobile accident-related are considered for benefits under this Plan, except under the life insurance and accidental death and dismemberment benefits.

Medically Necessary means any service, supply, treatment, or hospital confinement that is essential for the diagnosis or treatment of the injury or illness for which it is prescribed or performed; meets generally accepted standards of medical practice; and is ordered by a physician. If not medically necessary, no benefits are payable.

The fact that a physician may prescribe, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the expense a covered charge.

Medicare means the health insurance program set forth in Parts A and B, Title XVIII of the Social Security Act of 1965, as amended.

Nurse means a Registered or Licensed Practical Nurse, or a Licensed Vocational Nurse who has the right to use the abbreviation “R.N.,” “L.P.N.,” or “L.V.N.”

Obstetrical Procedure means one of the obstetrical procedures listed below:

- an abdominal operation for extra uterine or ectopic pregnancy;
- the delivery of a child(ren) by means of a cesarean section;
- the delivery of a child(ren) by means other than a cesarean section; or
- services in connection with miscarriage, with or without dilation and curettage.

The term “prenatal care” means care rendered in the physician’s office, prior to termination of pregnancy. The term “postnatal care” means care rendered in the physician’s office during the 90-day period following termination of pregnancy. Postnatal care does not include any care rendered to the newborn child or children.

Pharmacy means a licensed establishment where prescription drugs are dispensed by a pharmacist.

Physician means a duly licensed doctor of medicine authorized to perform medical or surgical services within the lawful scope of his practice and also includes any other health care provider or allied practitioner as mandated by state law.

Reasonable and Customary Charges means the amount normally charged for similar services and supplies that does not exceed the amount ordinarily charged for comparable services and supplies in the locality where the patient resides. In determining whether charges are reasonable and customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances that require additional time, skill, or experience.

Skilled Nursing Care and Services means one or more of the professional services and care that may be rendered by a registered professional nurse or by a licensed practical nurse under the direction of a registered professional nurse.

Totally Disabled means that

- you’re prevented, because of injury or disease from engaging in your customary occupation and are performing no work of any kind for pay or profit; or
- you’re prevented, because of injury or disease, from engaging in substantially all the normal activities of a person of like age and sex in good health.

The Board of Trustees

The names and addresses of the Health and Welfare Fund Trustees as of the date this Summary Plan Description was issued are as follows:

Union Trustees	Employer Trustees
Louis A. Mandarini, Jr. Chairman Laborers' Local Union #22 35 Highland Avenue Malden, MA 02148 Tel: 781-321-6616/6626 Fax: 781-321-6662	**John A. Farina** Secretary/Treasurer James Farina Corp. 120 Adams Street P. O. Box 600269 Newton, MA 02460 Tel: 617-332-8650 Fax: 617-527-5380
Joseph Bonfiglio Co-Chairman Laborers' Local Union #151 238 Main Street Cambridge, MA 02142 Tel: 617-876-8081 Fax: 617-492-0490	**Richard McCourt** Co-Secretary/Treasurer McCourt Construction Company 60 "K" Street South Boston, MA 02127 Tel: 617-269-2330 Fax: 617-269-2313
Thomas Troy Laborers' Local Union #1421 623 Main Street Woburn, MA 01801 Tel: 781-933-1401 Fax: 781-933-1403	**Thomas J. Gunning** Building Trades Employers Assoc. 150 Grossman Drive, Suite 313 Braintree, MA 02184 Tel: 781-849-3220 Fax: 781-849-3223
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The Board of Trustees consists of an equal number of Union and Employer representatives who serve without compensation.

Massachusetts
Laborers