PLAN SUMMARIES OF MATERIAL MODIFICATION

2018-2020

HEALTHCARE • PENSION • ANNUITY

BENEFITS FOR LABORERS

MASSACHUSETTS

LABORERS' BENEFIT FUNDS

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

P. O. BOX 1501 • 1400 DISTRICT AVENUE • SUITE 200
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TELEPHONE (781) 272-1000 • TOLL FREE (800) 342-3792 • FAX (781) 238-0703

May 2018

Dear Member and Family:

The Trustees of the Massachusetts Laborers' Health and Welfare Fund (the "Fund") would like to advise you of changes to the Fund's Claims and Appeals Procedures. Effective January 1, 2018, the Fund became a non-grandfathered health plan under the Affordable Care Act (ACA). Consequently, the Trustees have adopted revised internal claims and appeals procedures and have added new external appeals procedures, as required of non-grandfathered plans under the ACA.

In addition, the Trustees have adopted revised internal claims and appeals procedures with respect to disability claims effective April 1, 2018, as required under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The revised internal claims and appeals procedures and the new external appeals procedures are reprinted in their entirety in the attached document. If you have any questions about the revised internal claims and appeals procedures or the new external appeals procedures, please contact the Fund Office at the address/phone number at the top of this notice.

Sincerely,

Board of Trustees

NOTE: This notice is intended as a Summary of Material Modification (SMM) for the Massachusetts Laborers' Health and Welfare Fund, Fund Number 501, as required by the Employee Retirement Income Security Act of 1974, as amended (ERISA). It describes changes to the information presented in your Summary Fund Description (SPD) booklet, plan communications and any previous SMMs. Please share it with your family and keep it for future reference.

Este aviso está disponible en español en el sitio de web www.mlbf.org.

CLAIMS AND APPEALS PROCEDURES

INTERNAL CLAIMS AND APPEAL PROCEDURES

This section describes the procedures followed by the Massachusetts Laborers' Health and Welfare Fund in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for medical, mental health, substance abuse, member assistance program (MAP), dental, vision, hearing, wellness, prescription drug, weekly accident and sickness, disability extension of coverage, life insurance and accidental death and dismemberment benefits.

The Fund's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Fund provisions are applied consistently with respect to you and other similarly situated participants and dependents. With respect to health benefit claims, the Fund must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not medically necessary or appropriate, or is experimental or investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Fund's internal appeals process.

For health benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Fund's internal appeals process has been exhausted, or (ii) under limited circumstances before the Fund's internal claims and appeals process have been exhausted.

General Information

Claims Administrator(s)

The Plan Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

Types of Claims	Appropriate Claims Administrator
Health Claims	Fund Office
Mental Health/Substance Abuse Claims	Fund office
Prescription Drug Claims	Express Scripts
Dental Claims	Delta Dental
Vision Claims	Davis Vision
Hearing Claims	Fund Office

Types of Claims	Appropriate Claims Administrator
Disability Claims	Fund Office
Life Insurance Claims	Ullico
Accidental Death and Dismemberment Claims	Ullico

Days Defined

For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.

Discretionary Authority of Fund Administrator and Designees

In carrying out their respective responsibilities under the Fund, the Fund Administrator, other Fund fiduciaries, Claims Administrators, and other individuals to whom responsibility for the administration of the Fund has been delegated, have discretionary authority to interpret the terms of the Fund and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Fund benefits in accordance with the terms of the Fund. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Fund or a determination that a benefit is not a covered benefit;

- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or

    - A rescission of coverage, whether or not there is an adverse effect on any particular health benefit claim or disability claim. An adverse benefit determination does not include rescissions of coverage with respect to life insurance or accidental death and dismemberment insurance benefits.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Definition of a Claim

A claim is a request for a Fund benefit made by you or your covered Dependent (also referred to as "claimant") or your authorized representative in accordance with the Fund's reasonable claims procedures.

Types of Claims

Health Benefit Claims

Health benefit claims can be filed for medical, mental health, substance abuse, MAP, dental, vision, hearing, wellness, and prescription drug benefits.

There are four categories of health benefit claims as described below:

- ***Pre-Service Claims*** (applicable to medical, mental health, substance abuse, MAP, and prescription drug benefits) – A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. This is referred to as preauthorization. Under this Fund, prior approval 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;
    - Complementary medical care (biofeedback, homeopathy, naturopathy, oriental medicine);
    - Hospice or home health care;
    - Non-emergency inpatient treatment for a mental or nervous condition, alcoholism, or substance abuse;
    - Durable medical equipment;
    - Gastric bypass or gastric sleeve surgery; and
    - Certain prescription drugs (refer to your Summary Fund Description [SPD] for information on how to obtain a list).

    If you fail to get prior approval for these services, **penalties could be complete denial of the claim**.

- ***Urgent Care Claims*** (applicable to medical, mental health, substance abuse, MAP, and prescription drug benefits) – An Urgent Care Claim is any Pre-Service Claim for health care treatment that if applying the time frames allowed for a Pre-Service Claim (i) could

seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Fund will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health. The Fund, 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.

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.

- ***Concurrent Claims*** (applicable to medical, mental health, substance abuse, MAP, dental, and prescription drug benefits) – A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated 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. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

- ***Post-Service Claims*** (applicable to medical, mental health, substance abuse, MAP, dental, vision, hearing, wellness and prescription drug benefits) – A Post-Service Claim is a request for benefits under the Fund that is not a Pre-Service Claim (for example, a claim submitted for payment after health services and treatment have been obtained). Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Disability Claims

A Disability Claim includes Weekly Accident and Sickness Claims and claims that require a finding that you are totally disabled (for example, to receive the disability extension described in your Summary Fund Description (SPD). Weekly Accident and Sickness Claims are filed after a participant suffers a disability and benefits are paid if the Claims Administrator determines that the participant has suffered a disability as defined by the terms of the Fund.

Life Insurance/Accidental Death and Dismemberment Insurance Benefit Claims

A Life Insurance/Accidental Death and Dismemberment Insurance Benefit Claim is a request by a designated beneficiary for benefit payment following the death of the participant. A claim for Accidental Death and Dismemberment Benefits may also be filed by a participant after he or she has provided the Fund with proof of a bodily loss.

Claim Elements

An initial claim must include the following elements to trigger the Fund's internal claims process:

- Be written (oral communication is acceptable only for Urgent Care Claims);
- Be received by the Fund Administrator or Claims Administrator (as applicable);
- Name a specific individual participant and his/her Social Security Number;
- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- Not made in accordance with the Fund's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Fund;

- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;

- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Fund;

- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Fund's contracted in-network vision provider(s). After the denial by the vision service provider, you may file a claim with the Fund.

If you submit a claim that is not complete or lacks required supporting documents, the Fund Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Fund's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

Filing a Claim

TYPE OF CLAIM	HOW TO FILE CLAIM
Pre-Service Claims For Medical Services Other Than Treatment Of A Mental Or Nervous Condition, Alcoholism, Or Substance Abuse	Your doctor should call Blue Cross Blue Shield 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 prior authorization request to 800-357-9577
Urgent Care Claims	Urgent Care 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. **Urgent claims must be submitted by telephone, fax (781-238-0703) or in person** (they may **not** be submitted via the U.S. Postal Service).
Post-Service Claims	Claim forms for post-service health benefit claims must be completed in full, and an itemized bill or bills must be attached.

TYPE OF CLAIM	HOW TO FILE CLAIM
Post-Service Health Benefit Claims For Non-Network Medical Benefits	Post-Service Health Care Claims for non-network medical benefits should be sent to the Fund Office at the following address: Massachusetts Laborers' Health and Welfare Fund, 1400 District Avenue, Suite 200, P.O. Box 1501, 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-04 or HCFA-1500, and file it directly with the Fund on your behalf.
Post-Service Claims For Non-Network Vision Care Benefits	Post-Service Claims for non-network vision care benefits should be sent to Davis Vision at the following address: Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110. Only one claim per service may be submitted for reimbursement each benefit cycle. To request claim forms, please visit the Davis Vision website at www.davisvision.com or call 800-999-5431.
Post-Service Claims For Non-Network Prescription Drug Benefits	Post-Service Claims for non-network prescription drug benefits 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.
Post-Service Claims For Non-Network Dental Benefits	Post-Service Claims for non-network dental benefits should be sent to Delta Dental of Massachusetts, P.O. Box 9695, Boston, MA 02114. You can download a claim form from the Web site www.deltadentalma.com or use a universal claim form.
Disability Claims	Disability claims should be sent to the Fund Office at the following address: Massachusetts Laborers' Health and Welfare Fund, 1400 District Avenue, Suite 200, P.O. Box 1501, Burlington, MA 01803-0900
Life Insurance and Accidental Death and Dismemberment Claims	Life insurance and accidental death and dismemberment claims should be sent to the Fund Office at the following address: Massachusetts Laborers' Health and Welfare Fund, 1400 District Avenue, Suite 200, P.O. Box 1501, Burlington, MA 01803-0900. The Fund Office will forward claims for life and accidental death and dismemberment benefits to the insurance company.

Claim Filing Deadlines

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 Claims and Urgent Care Claims

Pre-Service and Urgent Care Claims must be filed **before services are obtained**.

Health Benefit Claims

Health benefit claims, including hearing benefit claims, must be submitted **within 90 days** of when expenses are incurred (or, if that is not reasonably possible, no later than one year after charges were incurred).

Dental Claims

Dental claims must be filed within one year of the date when you receive the service.

Disability Claims

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

Life and Accidental Death and Dismemberment Claims

Claims for life insurance and accidental death and disability benefits must be filed within 90 days of the loss.

Initial Claim Decision Timeframes

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Fund's reasonable filing procedures, regardless of whether the Fund has all of the information necessary to decide the claim. A claim may be filed by you, your covered dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be your authorized representative.

Health Benefit Claims – Decision Timeframes

The Fund will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Fund issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as

possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

- **Pre-Service Claims** (applicable to medical, mental health, substance abuse, MAP, and prescription drug benefits)

  Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt by the appropriate Claims Administrator. You will be notified in writing within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

  The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written notification before the expiration of the initial fifteen (15) day determination period.

  If you improperly file a Pre-Service Claim, the Claims Administrator will notify you in writing as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, you must re-file a claim to begin the Pre-Service Claim determination process.

  If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, you will have 45 days following your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Claims Administrator receives your response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing.

- **Urgent Care Claims** (applicable to medical, mental health, substance abuse, MAP, and prescription drug benefits)

  In the case of an Urgent Care Claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Fund to be your authorized representative bypassing the need for completion of the Fund's written authorized representative form.

  The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Claims Administrator will orally communicate its decision telephonically to you. The determination will also be confirmed in writing no later than three (3) days after the oral notification.

If you improperly file an Urgent Care Claim, the Claims Administrator will notify you as soon as possible, but in no event later than 24 hours after receiving the claim. The written notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, you must re-file a claim to begin the Urgent Care Claim determination process.

If a claim cannot be processed due to insufficient information, the Claims Administrator will provide you with a written notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, you will have not less than 48 hours following receipt of the notice to supply the additional information. If you do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written notice of the decision will be provided to you no later than 48 hours after the Claims Administrator receives the specific information or the end or the period given for you to provide this information, whichever is earlier.

- **Concurrent Claims** (applicable to medical, mental health, substance abuse, MAP, dental, and prescription drug benefits)

  If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

  A Concurrent Claim that is an Urgent Care Claim will be processed according to the Fund's internal appeals procedures and timeframes described above under the Urgent Care Claim section.

  A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Fund's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

  If the Concurrent Care Claim is approved you will be notified orally followed by written notice provided no later than three (3) calendar days after the oral notice.

  If the Concurrent Care Claim is denied, in whole or in part, you will be notified orally with written notice.

- **Post-Service Claims** (applicable to medical, mental health, substance abuse, MAP, dental, vision, hearing, wellness, and prescription drug claims)

  Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Administrator. You will be notified in writing within the 30-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by fifteen (15) days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written notification before the expiration of the initial 30-day determination period.

If a claim cannot be processed due to insufficient information, the Claim Administrator will notify you in writing about what information is needed before the expiration of the initial 30-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing.

Disability Claims – Decision Timeframes

Disability Claims will be decided no later than 45 days after receipt by the appropriate Claims Administrator. You will be notified in writing within the 45-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by 30 days due to circumstances beyond the Claim Administrator's control; provided you are given written notification before the expiration of the initial 45-day determination period. A decision will be made within 30 days of the date the Claims Administrator notifies you of the delay. The period for making a decision may be delayed an additional 30 days if due to matters beyond the control of the Claims Administrator, provided you are notified of the additional delay, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing about what information is needed before the expiration of the initial 45-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has 30 days to make a decision and notify you in writing.

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

Life Insurance/Accidental Death and Dismemberment Insurance Benefits – Decision Timeframe

Generally, you will receive written notice of a decision on your initial claim within 90 days of receipt of your claim by the Claims Administrator. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Claims Administrator, you will be notified in writing within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

Initial Determinations of Benefit Claims

Notice of Adverse Benefit Determination

If the Claims Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- Identify the claim involved (and for health benefit claims, include the date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (and for health benefit claims, include a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however such a request is not considered to be a request for an internal appeal or external review for health benefit claims);
- If the denial is based on a Fund standard that was used in denying the claim, a description of such standard.
- Reference the specific Fund provision(s) on which the denial is based;
- Describe any additional material or information needed to perfect the claim and an explanation of why such added information is necessary;
- With respect to health benefit claims and disability claims, the opportunity, upon request and without charge, for reasonable access to and copies of all documents, records and other information relevant to an initial claim for benefits;
- Provide an explanation of the Fund's internal appeal and external review processes for health benefit claims, along with time limits and information about how to initiate an appeal and an external review for health benefit claims;
- Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;

- With respect to health benefit claims and disability claims, if the denial was based on an internal rule, guideline, protocol, standard or similar criteria, a statement will be provided that a copy of such rule, guideline, protocol, standard or similar criteria that was relied upon will be provided to you free of charge upon request;

- If the denial of a health benefit claim or disability claim was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request;

- With respect to disability claims, a discussion of the Fund's initial claim discussion, including the basis for disagreeing with: (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Fund does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Fund, regardless of whether or not the advice was relied upon by the Fund in making an adverse benefit determination;

- For Urgent Care health benefit claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written notification; and

- With respect to health benefit claims, provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Fund's internal claims and appeal processes as well as with the external review process.

Notice of Approval of Pre-Service and Urgent Care Claims

If a Pre-Service claim is approved, you will receive written notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing to you within the applicable timeframe after the Claims Administrator's receipt of the claim.

Internal Appeal Request Deadline

- ***Health Benefit Claims*** (applicable to medical, mental health, substance abuse, MAP, dental, vision, hearing, wellness, and prescription drug benefits)

  If an initial health care claim is denied (in whole or in part) and you disagree with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Fund will not accept appeals filed after this 180-day period. Under limited circumstances,

explained below in the section on External Review, you may bypass the Fund's internal claims and/or appeal processes and file a request for an external review.

Specifically 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 Fund's Board of Trustees.

Specifically for hearing benefit claims, you must exhaust the appeals process with HearUSA first. You may then file a voluntary appeal with the Fund's Board of Trustees.

- ***Disability Claims***

  If an initial Disability Claim is denied and you disagree with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an internal appeal. The Fund will not accept appeals filed after this 180-day period.

- ***Life Insurance/Accidental Death and Dismemberment Insurance Benefits***

  If an initial life insurance/accidental death and dismemberment benefit claim is denied and you disagree with the Claims Administrator's decision, you or your authorized representative may request an appeal. You have 60 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an appeal. The Fund will not accept appeal requests filed after this 60-day period.

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.

Internal Appeals Process

Appeal Procedures

- ***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. Appeal requests 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.

- ***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 Accidental Death and Dismemberment Claim Appeals***

  For Life Insurance and Accidental Death and Dismemberment Claim appeals, there is one level of appeal at the Fund Office. The Fund Administrator will review the claim appeal.

To file an internal appeal, you must submit a written statement to the Fund at the following address:

1400 District Avenue, Suite 200
P. O. Box 1501
Burlington, Massachusetts 01803
Telephone: (781) 272-1000
Toll Free (800) 342-3792
Fax (781) 272-2226

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Fund will provide you with:

- The opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;

- The opportunity to submit to the Fund written comments, documents, records and other information relating to your initial claim for benefits;

- With respect to health benefit claims appeals and disability claims appeals, a reasonable opportunity to respond to new information by presenting written evidence and testimony;

- A full and fair review by the Fund that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;

- With respect to health benefit claims and disability claims, the Fund will automatically provide you free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the denied initial claim. The Fund will automatically provide you with any new or additional evidence or rationale as soon as possible once it becomes available to the Fund and sufficiently in advance of the date on which notice of an adverse determination on appeal is scheduled to be provided to you. New or additional evidence or rationale will be provided to you so that you have a reasonable opportunity, sufficiently in advance of

the date on which a notice of an adverse benefit determination upon appeal is required to be provided, to respond to the Fund regarding such evidence. If the new or additional evidence or rationale is received by the Fund so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the period for providing a notice of a final adverse benefit determination will be delayed (tolled) until you have had a reasonable opportunity to respond. After you respond (or do not respond after having a reasonable opportunity to do so), the Fund (acting in a reasonable and prompt manner) will notify you of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies.

- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Fund who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- With respect to health benefit claims appeals and disability claims appeals, continued coverage during the pendency of the appeal process; and

- In deciding an appeal of any adverse benefit determination regarding a health benefit claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or appropriate, the fiduciary or fiduciaries will:

    - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment; and

    - Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and

    - The Fund will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

- ***Health Benefit Claims***

    - ***Pre-Service Claims*** *(applicable to medical, mental health, substance abuse, MAP, and prescription drug benefits)*. A determination will be made and a written notice regarding the appeal will be sent to you within 30 days from the date your written request for an appeal is received by the Fund.

    - ***Urgent Care Claims*** *(applicable to medical, mental health, substance abuse, MAP, and prescription drug benefits).* This is an expedited internal appeals

process under which a written notice regarding a decision on the approval or denial of the expedited internal appeal will be sent to you (and your health care professional) no later than within 72 hours of the Fund's receipt of your (oral or written) request for appeal. If your situation involves an urgent medical condition, which the timeframe for completing an expedited internal appeal would seriously jeopardize your ability to regain maximum function, and the claim involves a medical judgment or a rescission of coverage, you may seek an expedited external review at the same time that you request an expedited internal appeal (you must seek both).

- **Concurrent Claims** *(applicable to medical, mental health, substance abuse, MAP, dental, and prescription drug benefits).* You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the Fund Office. A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

- **Post-Service Claims** *(applicable to medical, mental health, substance abuse, MAP, dental, vision, hearing, wellness, and prescription drug benefits).* Under the Fund's two (2) level appeal process, the Fund routes the first level of review to the appropriate Claims Administrator who will make the first level determination on the appeal of your initial Post-Service Claim no later than 30 calendar days from the Fund's receipt of the appeal request. Within this 30-day period, you will be sent a written notice of the appeal determination.

  If the first level appeal determination results in an adverse benefit determination, you will have 60 calendar days from your receipt of a notice of adverse benefit determination to request a second level appeal review by writing to the Fund Office. The Fund will then make a second level determination no later than the date of 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***

Under the Fund's two (2) level appeal process, a written notice regarding the first-level decision on your appeal will be sent to you within 45 days from the date your written request for an appeal is received by the Fund. If the first level appeal determination results in an adverse benefit determination, you will have 60 calendar days from your receipt of a notice of adverse benefit determination to request a second level appeal

review by writing to the Fund Office. The Fund will then make a second level determination no later than the date of 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 Insurance/Accidental Death and Dismemberment Insurance Benefit Claims***

  A written notice regarding a determination of your appeal will be sent to you within 60 days from the date your written request for an appeal is received by the Fund.

Notice of Adverse Benefit Determination upon Appeal

A written notice of the appeal determination must be provided to you that includes:

- The specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code applicable to a health benefit claim (if any) and its corresponding meaning, (ii) a description of the Fund's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;

- Reference the specific Fund provision(s) on which the denial is based;

- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;

- A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review regarding the denied internal appeal of a health benefit claim;

- If the denial of a health benefit claim or disability claim was based on an internal rule, guideline, protocol, standard or similar criterion, a statement must be provided that such rule, guideline, protocol, standard or criteria will be provided free of charge, upon request;

- If the denial of a health benefit claim or disability claim was based on a medical judgement (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request;

- With respect to disability claims, a discussion of the Fund's initial claim discussion, including the basis for disagreeing with: (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Fund does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Fund, regardless of whether or not the advice was relied upon by the Fund in making an adverse benefit determination; and

- With respect to a health benefit claim, disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

This concludes the appeal process under this Fund. The Fund does not offer a voluntary appeal process unless you exhaust the appeals process with Delta Dental. You may then file a voluntary appeal with the Fund's Board of Trustees.

Authorized Representative

The Fund recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file an initial claim and appeal an adverse benefit determination under the Fund. An authorized representative under the Fund also includes a health care professional. You do not need to designate in writing that the health care professional is your authorized representative if that health care professional is part of the claim appeal. A health care provider with knowledge of your medical condition may act as your authorized representative in connection with an Urgent Care Claim without filing a written statement with the Fund.

The Fund requires you to provide a written statement declaring your designation of an authorized representative (except for a health care professional who does not require a written statement in order to appeal a claim for a claimant) along with the representative's name, address, phone number, and email address. To designate an authorized representative, you must submit a completed authorized representative form (available from the Fund Office).

If you are unable to provide a written statement, the Fund will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g.* notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the your legal spouse, parent, grandparent, or child over the age of 18).

Once the Fund receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative rather than to you. The Fund will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Fund Office. The Fund reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

Limitation on When a Lawsuit May Be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Fund benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Fund's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. With respect to health benefit claims and disability claims, 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 Fund has failed to follow them properly.

In addition, with respect to health benefit claims, you are not required to exhaust external review before seeking judicial remedy.

No lawsuit 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 Fund pay) upon which the lawsuit is based.

Because the Fund grants its fiduciaries discretionary authority to determine eligibility for benefits and to construe the terms of the Fund, 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.

Elimination of Conflict of Interest

With respect to health benefit claims and disability claims, to ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators, medical professionals and vocational experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Facility of Payment

If the Fund or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Fund because you are incompetent, incapacitated or in a coma, the Fund may, at its discretion, pay Fund benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Fund benefits will completely discharge the Fund's obligations to the extent of that payment.

EXTERNAL APPEALS PROCEDURES

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Fund's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

Claims Eligible for the External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Fund's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment.

- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible For the External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.

- A determination that you or your dependent are not eligible for coverage under the terms of the Fund.

- Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review.

- Claims as to which the Fund's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).

- Claims that relate to benefits other than health care benefits (such as disability benefits, death benefits, and dental/vision benefits that are considered excepted benefits).

- Claims that relate to benefits that the Fund provides through insurance. Claims that relate to benefits provided through insurance are subject to the insurance company's external review process, not this process.

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Fund's internal appeals process. A "final" adverse benefit determination means the Fund has continued to deny your initial claim in whole or part and you have exhausted the Fund's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Fund waives the requirement that you complete its internal claims and appeals process first.

- In an urgent care situation (see "Expedited External Review of an Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.

- If the Fund has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Fund disagrees, you may request that the Fund explain in writing why you are not entitled to seek external review at this time.

External Review of a Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must made in writing within four (4) months after you receive notice of an adverse benefit determination.

Because the Fund's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Fund's internal claims and appeals process.

To begin the standard external review process, contact the Fund Office at:

1400 District Avenue, Suite 200
P. O. Box 1501
Burlington, Massachusetts 01803
Telephone: (781) 272-1000
Toll Free: (800) 342-3792
Fax: (781) 272-2226

Preliminary Review of a Standard (Non-Urgent Care) Claim by the Fund

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

- You are/were covered under the Fund at the time the health care item or service is/was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided.

- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Fund; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.

- You have exhausted the Fund's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed).

- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Fund will notify you in writing whether:

- Your request is complete and eligible for external review.

- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).)

- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four (4) month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

Review of a Standard (Not Urgent Care) Claim by the IRO

If your request is complete and eligible for external review, the Fund will assign it to an accredited IRO. The Fund has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review.

- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10) business day deadline.

- Within five (5) business days after the claim has been assigned to the IRO, the Fund will provide the IRO with the documents and information it considered in making its adverse benefit determination.

- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Fund within one (1) business day. Upon receipt of any such information (or at any other time), the Fund may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Fund will not delay the external review. If Fund reverses its determination after it has been assigned to an IRO, the Fund will provide written notice of its decision to you and the IRO within one (1) business day. Upon receipt of such notice, the IRO will terminate its external review.

- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Fund's previous internal claims and appeal decisions. However, the IRO must review the Fund's terms to ensure that its decision is not contrary to the terms of the Fund, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Fund's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Fund, reports from appropriate health care professionals, appropriate practice guidelines, the Fund's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

- In a standard case, the IRO will provide written notice of its final decision to you and the Fund within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial.

- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.

- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.

- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon.

- A statement that the IRO's decision is binding on you and the Fund, except to the extent that other remedies may be available to you or the Fund under applicable state or federal law.

- A statement that judicial review may be available to you.

- A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Expedited External Review of an Urgent Care Claim

You may request an expedited external review in the following situations if:

- You receive an adverse benefit determination regarding your initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal.

- You receive a "final" adverse benefit determination after exhausting the Fund's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

To begin a request for expedited external review, contact the Fund Office at:

1400 District Avenue, Suite 200
P. O. Box 1501
Burlington, Massachusetts 01803
Telephone: (781) 272-1000
Toll Free: (800) 342-3792
Fax: (781) 272-2226

Preliminary Review of an Urgent Care Claim by the Fund

Immediately upon receipt of a request for expedited external review, the Fund will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Fund will defer

to your attending health care professional's determination that a claim constitutes "urgent care." The Fund will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review of an Urgent Care Claim by the IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Fund will assign an accredited IRO. The Fund has arranged for at least three (3) accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Fund will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim *de novo* meaning that it is not bound by any previous decisions or conclusions reached during the Fund's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Fund's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Fund within forty-eight (48) hours after it is made.

What Happens after the IRO Decision is Made?

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

- If the final external review upholds the Fund's internal adverse benefit determination, the Fund will continue not to provide coverage or payment for the reviewed claim.

- If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA section 502.

Massachusetts Laborers' Recovery Program

MASSACHUSETTS LABORERS' BENEFIT FUNDS

Effective October 1, 2018 (amended 09/01/2019)

The Trustees of The Massachusetts Laborers' Health and Welfare Fund are pleased to introduce a comprehensive program, including Medication-Assisted Treatment and Peer Recovery Support, to assist members and their families with Substance Abuse issues.

Laborers' Recovery Specialists

Help is available 24/7! The Fund will have dedicated Peer Recovery Support Specialists available to help you and your family on the road to recovery. They are Laborers that have made the journey from illness to wellness, and now want to help others. The Recovery Specialists will serve as guides to initiate, achieve and sustain long-term recovery from addiction including medication assisted, faith based, 12 step and other pathways to recovery. Recovery coaches provide connections in navigating recovery supportive systems and resources. You can reach a Recovery Specialist at **781-345-4131**.

- ✓ Need help locating treatment? – Help is here!
- ✓ Need help for a coworker or family member? – Help is here!
- ✓ Need someone to locate or establish a meeting? - Help is here!
- ✓ Need someone just to listen and understand – Help is here!
- ✓ Participation is always confidential!

Medication Assisted Treatment

The Fund will cover Medication Assisted Treatment (MAT) utilizing Buprenorphine/Naloxone (Suboxone). Effective 09/01/2019, coverage expanded to include Methadone. The Fund's Program places emphasis on the treatment portion of MAT. Coverage will not be allowed for Medication ***as*** treatment.

What members need to know:

- ✓ You may fill up to a 60-day supply per lifetime without an authorization.
- ✓ The maximum daily dosage allowed is 16mg. Effective 09/01/2019, Maximum daily dose allowed increased to 24mg.
- ✓ You must be participating in sessions with a licensed counselor to obtain authorization*.
- ✓ You must contact the Member Assistance Program at 1-800-522-6763 to obtain authorization prior to filling a script after the initial 60 days.
- ✓ A new authorization must be obtained for every 30-day prescription.
- ✓ Your prescription must be written by a provider that follows program rules, such as random drug testing, film counts and titration trials. If your provider does not comply, you will be directed to another prescriber.
- ✓ A Laborers' Recovery Specialist will reach out to you to assist you on your path to wellness.

*Contact the Fund office at 1-800-342-3792 for additional guidance on the number of counseling sessions required for authorization

MASSACHSETTS LABORERS'
BENEFIT FUNDS

LASER VISION CORRECTION (LASIK) BENEFITS COMING SOON!

September 2019

The Trustees of the Massachusetts Laborers' Health and Welfare Fund are pleased to announce a new benefit available through your Davis Vision Plan effective **October 1, 2019.**

What is LASIK?

Laser vision correction is a procedure that can reduce or eliminate your dependence on glasses or contact lenses. The FDA-approved procedure reshapes the cornea so that the light entering your eye is properly focused onto the retina.

What will the Fund Pay?

The Fund will pay $1,000 per eye (once per lifetime) when services are rendered by an in-network provider.[1] To be considered a candidate, you must be at least 18 years old, have healthy eyes and a stable eye prescription for the last twelve months.

How do I access the LASIK Benefit?

To be eligible for the benefit, including Davis Vision contracted prices for LASIK, members must contact QualSight, the LASIK network administrator, at 855-502-2020 prior to scheduling exam. The QualSight representative will assist you with selecting a local in-network provider and setting up an appointment that works for you!

Have Questions?

Feel free to call the Fund office at **1-800-342-3792**. We are happy to answer your questions!

This notice is intended as a Summary of Material Modification (SMM) for the Massachusetts Laborers' Health and Welfare Fund, Plan Number 501, as required by ERISA. It describes changes to the information in your current Summary Plan Description (SPD).

1. Out of Network Benefits will be allowed only when there is no participating provider within a 30-mile radius of your home address.

IMPORTANT NOTICE TO PARTICIPANTS OF THE MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

This document is a Summary of Material Modifications ("SMM") intended to notify you of an important change made to the Massachusetts Laborers' Health and Welfare Fund (the "Fund"). You should take the time to read this SMM carefully. If you have any questions regarding these changes to the Plan, please contact the Fund Office at 781-272-1000 or 1-800-342-3792.

Date: November 1, 2019

To: All Participants of the Massachusetts Laborers' Health and Welfare Fund and their Covered Dependents

From: The Board of Trustees

As you are aware, the Trustees are proud of the significant level of benefits that are provided to you through the Massachusetts Laborers' Health and Welfare Fund.

As Trustees to the Plan, we continually monitor the financial stability of the Plan to ensure that the Plan will continue to provide these important benefits well into the future.

Effective October 1, 2019

The purpose of this notice is to clarify and confirm that the Plan covers medically necessary, FDA approved gene therapy under either the medical benefit or the prescription drug plan. Benefits for gene therapy will be provided in accordance with the Fund's terms and limitations, including those relating to deductibles, copayments, coinsurance, pre-authorization, medical necessity and out-of-network providers. Please note that all gene therapy requires pre-authorization. This benefit clarification is incorporated into the Fund's Summary Plan Description ("SPD").

Also, the "Definitions" section of the SPD is amended to include the definition of Gene Therapy as follows:

- **Gene Therapy**: Gene therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. Illustrative examples of gene therapy include Chimeric Antigen Receptor T-Cell (CAR-T) Therapies such as Kymriah and Yescarta, as well and Luxturna and Zolgensma.

The Board of Trustees will review the list of emerging gene therapies from time to time to determine whether such emerging gene therapies should be covered under the Plan. Please also

note that other treatments for at least some of the medical conditions that these therapies would treat do exist. You should refer to the SPD for a detailed description of your benefits.

Of course, if any claim is denied in whole or part, you have the right to appeal that denial based on the procedures as detailed in the SPD.

If you have any questions regarding the above please feel free to contact the Fund Office at 781-272-1000 or 1-800-342-3792.

Sincerely,

BOARD OF TRUSTEES
Massachusetts Laborers' Health and Welfare Fund

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. Except to the extent that this SMM modifies the Plan, if any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees (or its duly authorized designee), reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement and the full Plan documents are at the Fund Office and may be inspected by you free of charge during normal business hours. No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters, legal and/or factual, arising under the Plan.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

PO BOX 1501•1400 DISTRICT AVENUE
BURLINGTON, MASSACHUSETTS 01803
TELEPHONE (781) 272-1000 • TOLL FREE (800) 342-3792 • FAX (781) 238-0703

This notice contains important information regarding your health care benefits

Date: April 30, 2020

To: Participants of the Massachusetts Laborers' Health and Welfare Fund

From: The Board of Trustees

The Board of Trustees is pleased to announce the following benefit improvements offered by your Health & Welfare Fund.

Effective March 1, 2020

Improved Benefit for ABA Therapy

The 20 hour per week benefit limit for Applied Behavior Analysis for children with a diagnosis of Autism Spectrum Disorder (ASD) has been removed. Hours allowed will be based on medical necessity and require authorization from The Laborers' Support Network (HMC Healthworks). The age limit for ABA therapy has also been extended. Medically necessary, in network services with authorization from the Laborers' Support Network will be covered for children ages 1-18. There is no coverage for out of network services. Authorization can be obtained by calling 1-800-522-6763.

Improved Benefit for Habilitative Speech Therapy

Habilitative Speech Therapy will no longer be included in the combined benefit of 60 visits per year for Outpatient Habilitative Care. Coverage of Outpatient Habilitative Speech therapy visits will be based on medical necessity and have no benefit maximum. Outpatient Habilitative Physical and Occupational Therapy will continue to have a combined benefit limit of 60 visits per calendar year. Plan Deductible, co-payments and Co-insurance apply. Coverage provided for In-Network providers only. To locate a provider, visit www.bcbsma.com, click on Find a Doctor, and search for Speech-Language Pathology in the PPO or EPO Network or call 1-800-810-2583.

If you have any questions regarding the information in this Notice, please contact the Fund Office.

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. Except to the extent that this SMM modifies the Plan, if any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees (or its duly authorized designee), reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the

Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the “Trust Agreement”). The Trust Agreement and the full Plan documents are at the Fund Office and may be inspected by you free of charge during normal business hours. No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters, legal and/or factual, arising under the Plan.

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MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

PO BOX 1501•1400 DISTRICT AVENUE
BURLINGTON, MASSACHUSETTS 01803
TELEPHONE (781) 272-1000 • TOLL FREE (800) 342-3792 • FAX (781) 238-0703

This notice contains important information regarding your health care benefits

Date: May 11, 2020

To: Participants of the Massachusetts Laborers' Health and Welfare Fund

From: The Board of Trustees

This notice describes important benefit changes that are being made to the Health and Welfare Fund in reaction to COVID-19. Please read it carefully and share it with your family.

CHANGES TO THE PLAN IN REACTION TO COVID-19

By now, everyone has heard of the "Coronavirus" or the illness it causes, known as "COVID-19". At a time like this, it is more important than ever to have health insurance, and as a Participant in the Fund, we have you covered. Your health plan provides a wide range of benefits including but not limited to coverage for office visits, hospitalization, and diagnostic testing (including testing for COVID-19). As always, we encourage you to use an In-Network Provider in order to receive the highest level of benefits.

If you and/or your dependents think you have been exposed to COVID-19 and develop a fever and/or symptoms of respiratory illness, such as a cough or shortness of breath, call your healthcare provider immediately. We encourage you to call your healthcare provider before presenting to an emergency room for treatment, to both ensure you have the quickest access to the specific services you need as well as to prevent the unnecessary exposure of yourself and any other patients or providers in the emergency room to the coronavirus without having taken appropriate protective measures.

Waiver of Cost Sharing for Detection of COVID-19

Effective for services received on or after March 18, 2020 and through the end of the emergency period in which the federal government has announced a National Emergency, the Fund will now cover the following services **from either an In-Network or Out-of-Network provider with no cost-sharing (for example, no copayments, deductibles or coinsurance).**

- COVID-19 Tests: COVID-19 in vitro diagnostic tests (including serological tests used to detect antibodies) that are approved by the Food and Drug Administration (FDA), for which the developer has requested emergency use authorization, or that are authorized by a state.

Related Tests: Items and services furnished during a provider "visit" that results in an order for, or administration of, a COVID-19 test, including related tests (e.g., blood tests or influenza tests), if the visit results in an order for, or administration of, a COVID-19 test. The term "visit" (e.g., office

visit, urgent care visit, emergency room visit or telehealth visit) also encompasses non-traditional settings such as drive-through sites where licensed healthcare providers administer the tests. These services will also be provided without any need for prior authorization or medical management. This means that you do not have to get precertification/prior authorization to have the tests or those visits covered.

Waiver of Cost Sharing for Treatment of Covid-19

Effective March 18, 2020, the Plan is providing benefits without cost sharing for the treatment of COVID-19-related conditions. Covered treatment under the Plan consists of medically necessary hospital, surgical, and other health care services that a covered person receives because of a non-occupational illness or injury for which benefits are not payable under Worker's Compensation Laws, provided such services are not otherwise excluded under the Plan. If an individual is receiving inpatient care for another condition and is diagnosed with COVID-19, regular cost-sharing requirements apply to treatment for that other condition (including general inpatient charges). The Trustees will determine whether a treatment is for the treatment of COVID-19-related conditions, based on the facts and circumstances. Coverage of COVID-19 treatment will be subject to all the rules and requirements of the Fund.

Plan will Now Cover Virtual or Telehealth Benefits

The Trustees are pleased to announce that the Plan will now cover virtual and/or telehealth visits. Generally speaking, telehealth means the use of electronic information and communication technologies including a telephone, smartphone, tablet or computer with a web cam, by a physician or other licensed provider to deliver covered services from a location that is different from a provider's office.

Telehealth visits are a convenient way for you and your covered dependents to access care. The service gives you quick and easy access to a doctor wherever you are. You can talk to a physician without leaving your house. In fact, it is recommended that members use telehealth when possible to help prevent the spread of infection and improve access to care. It is a safe and effective way to receive medical guidance for many medical issues, including those related to COVID-19, from your home using your telephone or online (depending on your doctor).

To be covered as telehealth services, the services must be furnished by health care providers who meet applicable state and federal telehealth regulations to be approved and qualified as a telehealth provider.

The following telehealth options are now available to you:

- As of April 1, 2020, you have access to go online and log on to ***Blue Cross and Blue Shield's Well Connection*** website at www.wellconnection.com. This program will allow you access to a panel of telemedicine providers if you do not have your own Primary Care Physician.

- As of April 1, 2020, you also have access to behavioral health telemedicine services through ***Arcadian Telepsychiatry***. To utilize this benefit, simply call the Laborers' Support Network at 800-522-6763 and request a telehealth referral. Arcadian Telepsychiatry will then reach out to you to schedule an appointment with one of their Psychiatrists, Psychiatric Nurse Practitioners, Therapists, and/or Social Workers.

- Additionally, the Fund will cover all telehealth visits provided by your own in-network physician (provided they have the capabilities).

During the COVID-19 emergency, there will be no cost sharing (deductibles, coinsurance, or copayments) for all in-network providers' delivery of clinically appropriate, Medically Necessary covered health services via telehealth to covered individuals. This benefit is not available for out-of-network providers (except as provided above for services related to testing for COVID-19). Please note that at the conclusion of this emergency period, routine office visit cost sharing will apply to all telehealth visits.

If you have any questions regarding the information in this Notice, please contact the Fund Office.

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. Except to the extent that this SMM modifies the Plan, if any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

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MASSACHUSETTS LABORERS

BENEFITS BULLETIN

CHANGES TO YOUR HEALTH AND WELFARE FUND COVERAGE

The Trustees of the Massachusetts Laborers' Health and Welfare Fund are dedicated to providing participants with comprehensive medical, prescription drug, dental and vision care. As costs for providing these benefits continue to skyrocket, the Trustees are always looking for ways to improve benefits and contain costs while making sure you have the coverage you need when you need it.

We've made a number of benefit improvements, but there are also some reductions. We know that while these will not apply to everyone, some of you may be affected. We are committed to helping you get the most from your coverage for the best cost, so please contact the Fund Office if you have any questions about these changes.

WHAT'S CHANGING?

BENEFIT IMPROVEMENTS:

EFFECTIVE JANUARY 1, 2018, THE FOLLOWING CHANGES WILL GO INTO EFFECT:

No Copays for Preventive Care!

Preventive care will be covered at 100% without a copayment. Preventive care includes certain screenings and immunizations that are appropriate for your age and gender. To see exactly what's covered and what's not, visit www.healthcare.gov.

More Protection Each Year

The Plan will have an out-of-pocket maximum for both medical and prescription drug coverage, beginning in 2018. This is a cap on the amount of copayments and coinsurance you pay for covered services in a calendar year. The most you can pay for medical care in calendar year 2018 is $6,350 per individual or $12,700 per family. If you reach this maximum in calendar year 2018, the Plan will pay 100% of covered expenses for the rest of the year. The out-of-pocket maximum for prescription drug expenses is $1,000 per individual or $2,000 per family.

Improved Hearing Aid Benefit

The hearing aid benefit will increase from $800 per hearing aid to $1,200 per hearing aid ($2,400 for two hearing aids). This benefit is available once every five years (per hearing aid) from the date of purchase.

We are pleased to announce that our new hearing care network will be HearUSA. HearUSA has nearly 4,000 audiologists and hearing care professionals in its network, along with more than 220 company-owned hearing centers. To schedule an appointment, call 800-442-8231 and identify yourself as a member of the Massachusetts Laborers.

Your new Hearing Care Network: HearUSA!

To set up a screening appointment or locate a HearUSA provider near you, visit www.hearusa.com or call 800-442-8231 and identify yourself as a Massachusetts Laborers' member.

Increase to Weekly Accident and Sickness Benefits

If you are sick or injured and cannot work (due to a non-work-related illness or injury), the Plan's Weekly Accident and Sickness benefit will pay you up to $400 per week during your absence. This is an increase of more than $125 per week. Refer to your Summary Plan Description for more information.

Greater Coverage for Children with Autism

The Health and Welfare Plan will offer greater coverage for Applied Behavioral Analysis (ABA) for children with Autism. Coverage will include up to 20 approved hours per week for dependent children aged 1 – 6 with an Autism Spectrum Disorder (ASD) diagnosis. Preauthorization from E4 (Member Assistance Program) is required.

WHAT'S CHANGING? IMPORTANT MODIFICATIONS:

No More Out-of-Network Coverage

The Plan's medical plan network through BlueCross BlueShield of Massachusetts has an extensive list of participating providers. To help contain costs, we will no longer be providing coverage if you seek care from a provider who is not part of the network, except in emergency situations. The PPO Plan will become an EPO (Exclusive Provider Organization). Here are some things to keep in mind:

- In-network only coverage applies to medical, surgical, mental health and substance use disorder benefits.
- Even if a facility participates in the network, it's possible that a provider, specialist or lab within that facility is not part of the network. To avoid unexpected costs, confirm that every provider you visit participates in the BCBSMA EPO network.
- Like a traditional PPO Plan, with an EPO there is no need to designate a primary care physician, and no referrals needed for specialist visits.
- Although you are not required to designate a primary care physician, we strongly encourage you to select one to help you manage and coordinate your care.

What if there are no providers near me in the EPO network?

There are times when there are no participating providers, of a specific type/specialty, within a certain number of miles of a member's home. In this case, we will provide benefits at an in-network level for the member to see a non-participating provider of the type/specialty in question. Benefits will be limited to Reasonable and Customary amounts.

***For example**, if a member needs to see an oncologist but there is no participating oncologist within the specified area of the member's home, the Plan will allow the member to see a non-participating oncologist at the in-network level of benefits.*

Keep an eye out for a new ID card!

You will be receiving a new BCBS identification card with the "Advantage Blue" logo for the BCBSMA EPO Plan. Please dispose of your PPO ID card and start using the new card beginning January 1, 2018.

$10 Increase in Some Copayments

Starting in 2018, copayments for certain covered expenses will increase from $20 to $30. These services include:

- Physician/Surgical Fees for outpatient surgery
- Specialist office visits

Emergency Services

- **ER Visits.** The new copayment will be $20 for physician's services + $150 for ER Facility charges for emergency room visits (waived if admitted to the hospital), for up to the first three visits. After that, the combined copayment will be $320 per visit for the remainder of the year. Currently, the Fund pays 100% after an additional $75 copayment for each emergency medical treatment (waived if admitted to the hospital), and after the initial $20 copayment.
- **Emergency Transportation (PLAN A Only).** The amount the Plan covers for emergency transportation before you begin paying coinsurance will drop from $50,000 to $20,000. If you reach $20,000, you'll pay 15% of the cost until you reach an out-of-pocket limit of $2,000. Then the Plan will begin to pay at 100% again.

If your condition isn't an emergency

We strongly encourage the use of in-network urgent care facilities in your area if your medical condition is not a true emergency. There's just a $20 copayment for an urgent care facility visit. To find one near you, visit www.bcbsma.com. But remember, if your condition is serious, please get to the ER right away. Don't put your health at risk!

Inpatient Charges: PLAN A Only

If you are an inpatient at a hospital or other facility (including for the treatment of a substance use disorder, mental/behavioral health, or for the birth of a child), the amount the Plan will pay before you begin paying coinsurance will decrease from $50,000 to $20,000. If you reach $20,000, you'll pay 15% of the cost until you reach an out-of-pocket limit of $2,000. Then the Plan will begin to pay at 100% again.

Increase to Copayments for Imaging Tests

Copayments for MRIs will increase to $100, and CT/Pet Scan copayments, regardless of where you receive them, will have a $20 copayment.

USE YOUR BENEFITS WISELY TO SAVE!

Your health and welfare plan was designed to provide you and your family with comprehensive coverage, but it includes many cost-saving components and programs to help keep participants' costs—and costs to the Fund—as low as possible. Make sure you're taking advantage of these features to become a better manager of your health care dollars.

It's becoming a necessity in the medical plan, but try to **visit in-network providers** for all of your benefit plans—prescription drugs (Express Scripts), dental (Delta Dental) and vision (Davis Vision), whenever possible. The Fund has pre-negotiated rates with in-network providers, meaning you'll generally pay less in deductibles, copayments and coinsurance.

If you take prescription drugs, be sure to **ask for the generic version**. Generics have the same active ingredients as their brand-name counterparts, but for just a $5 copay for a 30-day supply. That's $10 less than the same drug in the brand-name form.

If you take prescription drugs on a regular basis, you might want to consider using **the mail-order program**. You won't just save money—you'll save time, too.

Take advantage of **preventive care benefits**! Many preventive care services will be available at no cost to you beginning January 1. Take the time to make an appointment for your routine physical exam, get your flu shot, and schedule the testing and screenings you need. Preventive care is the key to protecting against costly medical expenses later on. The Health and Welfare Plan offers other resources and benefits for staying healthy too, like:

- A **fitness reimbursement benefit** that helps you cover the cost for a qualified gym membership.
- Monthly **massage therapy** and **nutritional counseling** benefits.
- A **tobacco cessation program** that provides free tools and support to help you quit tobacco.
- A **Member Assistance Program** (MAP) that can help you battle life's stresses with free counseling and other resources.

Review the Explanation of Benefits (EOB) statement that you receive after a doctor's visit. Small mistakes can add up to big dollars.

Save the Emergency Room for true emergencies. If it's not an actual emergency, an Urgent Care Facility, a call to the 24-hour BlueCare Line, or a trip to your doctor's office can be a major cost savings.

Most importantly, **keep yourself healthy!** Eat right, stay in shape, and get your annual check-ups.

Confirm ALL providers are in-network!

Sometimes, an in-network physician may refer you to a specialist, lab or facility that is not part of the BCBSMA EPO network. Make sure to double check that the provider you're visiting is part of the BCBSMA EPO network to avoid having to cover 100% of costs.

FREQUENTLY ASKED QUESTIONS

WHY ARE THE TRUSTEES MAKING THESE CHANGES?

There are several reasons. As Trustees of the Health and Welfare Fund, our goals are to:

- provide quality benefits that meet the needs of our members;
- ensure the Plan's financial stability; and
- comply with all legislative guidelines.

To this end, we periodically review our contracts with insurance carriers to seek out better deals and service in the marketplace. We make improvements when we can, but health care costs also often dictate a need to make reductions. When it's necessary, we aim to implement benefit reductions that will have the lowest impact on members while still providing the best coverage we can afford.

Losing Grandfathered Status

Because our Plan was established prior to 2010, we were able to exercise our right to not implement every provision required by the Affordable Care Act. This gave our Plan "Grandfathered" status. However, with the changes we are implementing, our Plan will lose this status on January 1, 2018. Therefore, some of the changes described in this bulletin are being made to comply with the Affordable Care Act. Others include:

- ***Emergency room care/emergency services.*** *Non-grandfathered health plans must cover emergency services without requiring prior authorization and without regard to the network status of the hospital or health care professionals involved in providing the emergency care. Additionally, non-grandfathered health plans must not impose any administrative or coverage limitations on out-of-network emergency services that are more restrictive than those that apply when emergency services are furnished in-network.*
- ***Internal claims and appeals and external review.*** *The ACA requires non-grandfathered health plans to revise their internal appeals processes and to adopt a new external appeals procedure.*
- ***Provider nondiscrimination.*** *Non-grandfathered health plans may not discriminate with respect to coverage or participation under the plan against health care providers who are acting within the scope of their license or certification under state law.*
- ***Clinical trials.*** *The ACA requires that routine costs of clinical trials related to cancer or other life-threatening illnesses be covered if the trial meets specific statutory requirements.*

MY DOCTOR IS NOT PART OF THE BCBS EPO NETWORK. WHAT SHOULD I DO?

Fortunately, BlueCross BlueShield of Massachusetts has an extensive network of providers, so we are hopeful that most participants will not be affected by this change. For a listing of providers in the network near you, visit www.bcbsma.com and click on "Find a Provider." If your provider or facility is not part of the EPO network, you can talk to the provider about joining the network.

There are times when there are no participating providers, of a specific type/specialty, within a certain number of miles of a member's home. In this case, we will provide benefits at an in-network level for the member to see a non-participating provider of the type/specialty in question. Benefits will be limited to Reasonable and Customary amounts.

WHAT IF I GO TO A PROVIDER OUTSIDE THE NETWORK FOR MEDICAL CARE? WHAT IF IT'S AN EMERGENCY?

If you decide to visit a provider outside of the network, you will be responsible for the entire cost. In an emergency situation, you may visit any emergency room, regardless of their participation in the BlueCross BlueShield of Massachusetts EPO network. For an out-of-network emergency room visit, you will be required to make the ER visit copay, plus you'll be responsible for any charges that exceed the Plan's allowed amount. However, if you are admitted to the hospital, the copay will be waived.

HOW DO I GET MORE INFORMATION ABOUT MY BENEFITS?

Who to Contact	How to Contact
The Fund Office For eligibility, claims or COBRA questions	www.MLBF.org 781-272-1000 or 800-342-3792
BlueCross BlueShield of Massachusetts For help finding providers	www.bcbsma.com 800-810-2583
E4 Health Member Assistance Program (MAP) Obtaining behavioral health pre-authorizations (including ABA services)	helloE4.com (User name: **mass laborers** Password: **guest**) 800-522-6763
Express Scripts To find a network pharmacy, get the status of mail-order prescriptions, copay inquiries, order ID cards and verify eligibility	www.express-scripts.com 800-467-2006
Delta Dental For questions about dental benefits or for help finding participating dentists	www.deltamass.com 800-872-0500 617-886-1234
Davis Vision For questions about vision benefits or for help finding network providers	www.davisvision.com 800-999-5431

WE'RE HERE TO HELP

You can always contact the Fund Office for assistance with finding a network provider, answering any questions or helping you understand your coverage.

Call us:
781-272-1000 or
800-342-3792

By appointment:
1400 District Avenue, Suite 200,
Burlington, Massachusetts 01803

We're here to help Monday through Thursday 7:00 – 4:30 and on Fridays 7:00 – 4:00.

SPECIAL PERKS PROVIDED BY BLUECROSS BLUESHIELD OF MASSACHUSETTS

Visit www.bcbsma.com to find out about the advantages of the BlueCross Blue Shield of Massachusetts network. Here are just a few features you can access:

- ***MyBlue App:*** Download the MyBlue app for a convenient way to look up your personal health care information quickly and easily from your smartphone or tablet.
- ***Find a Doctor:*** Visit https://myfindadoctor.bluecrossma.com/ for a routinely updated list of network providers in your area.
- ***A Healthy Me:*** Check out www.ahealthyme.com/ to find a comprehensive resource library including newsletters, a wellness portal, videos, quizzes and other tools to help you meet your health and wellness goals.
- ***24-Hour Nurseline:*** Speak with a registered nurse 24 hours a day, 7 days a week at no cost. If you're not feeling well and you're unsure about your options for care, call 888-247-BLUE (2583) and explain your situation/symptoms. The nurse will tell you whether you should see your doctor, go to the emergency room, or care for yourself at home.
- ***Deals and Discounts:*** Visit www.blue365deals.com for discounts on a variety of wellness-related brands and services from personal care to fitness.

This bulletin serves as a summary of plan changes and features and is not intended to replace or interpret the official plan documents that set forth the provisions of the health and welfare plan. If there is any discrepancy between what is described in this bulletin and what is contained in the plan documents, the plan documents will govern in all cases. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

MASSACHUSETTS LABORERS'
HEALTH & WELFARE FUND