

**METAL LATHERS  
LOCAL 46**

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**WELFARE TRUST FUND**

**EFFECTIVE JANUARY 1, 2002**

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**METAL LATHERS TRUST FUND LOCAL 46**

260 East 78<sup>th</sup> Street  
New York, New York 10021  
(212) 535-2323

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New York, NY 10021

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New York, NY 10014

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New York, NY 10018

**Fund Director**

Anthony D'Amico

**Co-Counsel**

Donald G. McCallion, Jr., Esq.  
Markowitz & Richman

**Consultants**

The Segal Company

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Dear Member:

We are pleased to present you with this new booklet which explains all of the health and welfare benefits to which you and your family are currently entitled.

There have been a number of important changes added to your program since the last printing of this explanation booklet.

This booklet contains the details of all of your health and welfare benefits including the eligibility rules. The Trustees have the right to interpret this document to determine eligibility and entitlement to benefits.

We suggest that you read this booklet carefully and that you share it with your family. We are happy to provide these benefits for you and your dependents. We will continue to try to maintain a secure welfare plan of benefits.

If you have any questions, please don't hesitate to contact the Fund Office.

Sincerely,

Board of Trustees

**General Provisions**

Introduction.....	1
Who is eligible for coverage? .....	1
When does your coverage start? .....	2
How does your coverage continue? .....	2
What if you become disabled? .....	2
When did you become eligible for Accident and Sickness Benefits? .....	3
Who are your covered dependents? .....	3
When does your dependents' coverage start? .....	4
When does your coverage end? .....	6
Certificate of Coverage When Coverage Ends .....	6
Accident and Sickness Benefits .....	7
Can you convert your coverage?.....	7
How do you file claims? .....	8
Coordination of benefits.....	8
<b>Health Benefits</b> .....	<b>11</b>
Hospital Insurance.....	11
365 – Day Hospital Plan .....	12
Pre-Certification.....	13
Large Case Management.....	13
Covered Inpatient Benefits.....	13
Inpatient Substance Abuse Care .....	14
Mandatory Second Surgical Opinion.....	15
Newborn Care/Maternity Coverage .....	16
Outpatient Hospital Benefits .....	17
Mammography Screening .....	17
Physical Therapy.....	18
Mental or Nervous Disorders .....	18
Outpatient Alcoholism and Substance Abuse Treatment .....	18
Home Care .....	18
Hospice Care .....	18
GHI Centers of Specialized Care .....	20

<b>Health Benefits (cont.)</b>	
Medical Insurance .....	23
Participating and Non-Participating Provider .....	23
Radiology Pre-Certification Program .....	27
Podiatry Pre-Certification Program .....	28
Durable Medical Equipment .....	28
Diabetes Management .....	30
What is not covered under GHI .....	30
Terminations and Conversions .....	32
Claims Appeal Procedure .....	32
Prescription Program .....	33
Extension of Benefits .....	34
How to file claims .....	36
Retire Health Coverage .....	38
Early Retirement .....	38
Vision Care Plan .....	39
<b>Member Assistance Program</b> .....	43
<b>Accident and Sickness Benefits</b> .....	44
<b>Life Insurance</b> .....	45
What your benefit is .....	45
If you become totally and permanently Disabled .....	45
Termination and Conversion .....	46
<b>Accidental Death and Dismemberment</b> .....	47
What your benefits are .....	47
What is not covered .....	47
Termination and Conversion .....	47
<b>COBRA Continuation Coverage</b> .....	48
<b>Health Care Coverage During a Leave of Absence</b> .....	55
<b>Other Important Information</b> .....	56
Claims and review procedure .....	60
Filing of claims .....	60
Review procedure .....	60
Decision on review .....	60
Rights of participants .....	61

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## GENERAL PROVISIONS

### INTRODUCTION

This Trust Fund is administered by Trustees representing both the Local 46 Metallic Lathers Union and Reinforcing Iron Workers of New York City and Vicinity and the Employers participating in the Plan. These Employers are referred to in this booklet as Contributing Employers.

All contributions to the Plan are made solely by Employers according to their collective bargaining agreements with Local 46 Metallic Lathers Union and Reinforcing Iron Workers of New York City and Vicinity. The collective bargaining agreements require contributions to the Plan at fixed rates for each hour worked.

Benefits are provided from the Fund's assets which are accumulated under the provisions of the collective bargaining agreement and the trust agreement, and are held in a trust fund for the purpose of providing benefits to covered participants and defraying reasonable administration expenses. Many of the benefits are provided through insurance policies.

### WHO IS ELIGIBLE FOR COVERAGE?

You are eligible for coverage under this Plan based upon hours of work in covered employment for which contributions are required to be made by an employer pursuant to a collective bargaining agreement with Local 46 Metallic Lathers Union and Reinforcing Iron Workers of New York and Vicinity.

#### **How to Enroll for Coverage**

After starting employment, the enrollment process will be included as part of your employment. However, if you do not receive the appropriate documentation, you must call the Fund Office to enroll yourself and/or your dependents for Plan coverage. You may do so once you satisfy the eligibility requirements as explained below.

#### **If You Acquire a Dependent**

If you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll these new dependents in the Plan immediately, provided you request his or her enrollment from the Fund Office within 30 days after the marriage, birth, adoption, or placement for adoption. Otherwise, coverage will begin on the first of the month following receipt of the documentation.

Depending upon your situation, you may have to submit paperwork to the Fund Office as part of the enrollment process for these dependents. When you notify the Fund Office of a change in your family status, you will be asked to submit the appropriate documents. For

example, if you get married, you may need to submit a copy of your marriage certificate to the Fund Office.

**When does your coverage start?**

Your coverage (except A&S benefits) starts on the January 1 or July 1 after you complete 450 hours of work in covered employment in the six-month period from January 1<sup>st</sup> – June 30<sup>th</sup>, or July 1<sup>st</sup> through December 31<sup>st</sup>.

**How does your coverage continue?**

Once you meet these initial eligibility requirements, your coverage will continue for a full calendar year if you worked at least 900 hours in covered employment in the prior calendar year.

*For example:*

Andy completed a total of 900 hours in 2000 (from January 1, to December 31). Therefore, his coverage will continue for all of 2001. If he completes 900 hours of covered employment in 2001, his coverage will continue for all of 2002.

**What if you become disabled?**

If you are unable to work at least 900 hours in a calendar year because you are disabled, *and* you are receiving accident and sickness benefits from this Fund, or Workers' Compensation benefits, you can continue to receive credit toward continued coverage. Each month in which you are disabled and receiving benefits, you will be credited the same average number of hours you worked during the six months before you became disabled, for a total of six months.

*For example:*

Harry is covered under the Metal Lathers Local 46 Trust Fund. He worked 1,000 hours between March 1 and September 1. On September 1, Harry became disabled and started to receive accident and sickness benefits from this Fund. He remained disabled until January 1.

Before Harry became disabled, he averaged 166 hours of work in covered employment during each of the previous six months ( $1,000 \div 6 \text{ months} = 166 \text{ hours per month}$ ). Harry will be credited with 166 hours for each of the four months he was disabled.

## **When do you become eligible for Accident and Sickness Benefits?**

The eligibility rules for accident and sickness benefits differ for new hires and those unemployed for more than 6 months and for those unemployed for less than 6 months.

### **New hires and those unemployed for more than six months**

You are eligible to receive accident and sickness benefits after you complete four weeks of work for a Contributing Employer. A week of work is any calendar week in which you work at least two full days. This four week delay in coverage will not apply if you change jobs and your previous employer was required to provide benefits under the New York State Disability Benefits Law.

### **For those unemployed less than six months**

If you are unemployed from covered employment for no more than six months and then return to work for a Contributing Employer for at least one day in the eight weeks immediately before you become disabled, your coverage begins on your first day of reemployment.

Please turn to page 45 for details on the amount of your weekly accident and sickness benefit.

## **WHO ARE YOUR COVERED DEPENDENTS?**

Your covered dependents include your spouse and your unmarried children. Your unmarried children are covered until December 31 of the year in which they turn 19. Children include natural children, stepchildren and adopted children or children placed for adoption if they depend upon you for support, (the Fund Office has the right to request legal documentation for the above.) When your children marry, they automatically become ineligible for benefits. You must notify the Fund Office in this event.

If your children are unmarried full-time students in an accredited institution and dependent upon you for support, all coverage can continue until the December 31 of the year in which they are 23 or until they are no longer full-time students, whichever occurs first.

If your children cannot support themselves because of physical handicap or mental illness, their coverage can continue beyond the age limitations described above. You must notify the Fund Office of your child's handicap within 31 days after coverage would otherwise end.

Your covered dependents are eligible for certain benefits provided by the Trust Fund. These benefits are:

- Group Health Incorporated health benefits
- Davis Vision benefits

They are *not* eligible for weekly accident and sickness benefits, life insurance, or accidental death and dismemberment coverage.

### **When does your dependents' coverage start?**

Coverage for your dependents starts on the date your coverage starts, or when they become your dependents, if later.

### **Special Enrollment**

In addition to adding new dependents, you can also enroll any dependents who did not enroll for coverage when they first became eligible because they had other health coverage.

### **Qualified Medical Child Support Orders (Special Rule for Enrollment)**

According to federal law, a qualified Medical Child Support Order (QMCSO) is a child support order that has been received by the Plan from a court or state administrative agency, usually as a result of a divorce or legal separation.

### **Definition of a QMCSO**

A QMCSO:

- Designates one parent to pay for a child's health care coverage.
- States the name and last known address of the parent required to pay for the coverage, as well as the name and mailing address of each child covered by the QMCSO.
- Describes the type and manner of coverage to be provided under the designated parent's health care plan.
- States the period for which the QMCSO applies.
- Identifies each health care plan to which the QMCSO applies.

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

If the employee is a Plan participant, the QMCSO may require the Plan to provide coverage for the employee's dependent child(ren) and to accept contributions for that coverage from a

parent who is not a Plan participant. The Plan will accept a special enrollment of the dependent child(ren), as specified by the QMCSO, from either the employee or the custodial parent. Coverage of the dependent child(ren) shall become effective as of the date the Plan receives the special enrollment. The dependent child(ren)'s coverage will be subject to all Plan terms and provisions, including the exclusion of pre-existing conditions, limits on provider selection, and requirements for authorization of services, insofar as is permitted by applicable law.

If the employee is not a Plan participant at the time the Plan Administrator, or its designee, receives the QMCSO, and the QMCSO orders the employee to provide coverage for his or her dependent child(ren), the Plan will accept a special enrollment for the employee and the dependent child(ren), as specified by the QMCSO. Coverage of the employee and his or her dependent child(ren) shall take effect on the date the Plan receives the special enrollment, and shall be subject to all Plan terms and provisions.

No coverage will be provided for any dependent child(ren) under a QMCSO unless the applicable employee contributions for that dependent child's coverage are paid, and all of the Plan's requirements for coverage of that dependent child have been satisfied.

Coverage of a dependent child under a QMCSO will terminate when coverage of the employee-parent terminates for any reason, including failure to pay any required contributions, subject to the dependent child's right to elect COBRA coverage if that right applies.

**If a Court or State Administrative Agency Order Is Not a QMCSO**

A court order is not a QMCSO if it:

- Requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide.
- Requires an employee, not covered by the Plan, to provide coverage for a dependent child (except as required by a state's Medicaid-related child support laws.)

In order for a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

## **WHEN DOES YOUR COVERAGE END?**

### **For You**

Your coverage ends on the earliest of these dates:

- The last day of the calendar year following a calendar year in which you work fewer than 900 hours.
- The date you die.
- The date that the Plan ends.

### **For Your Dependents**

Your dependents' coverage ends on the earliest of the following dates:

- When your coverage ends.
- When he or she no longer qualifies as an eligible dependent.
- The date that the Plan ends.
- Coverage for all of your dependents ends at the end of the third month following the month in which you die.

However, you may be eligible to continue coverage on a self-pay basis, (see [page 49](#) "COBRA Continuation Coverage").

### **Certificate of Creditable Coverage**

When your coverage ends you and/or your covered dependents are entitled by law to, and will be provided with, a certificate of creditable coverage. Certificates of creditable coverage indicate the period of time you and/or your dependent(s) were covered under the Plan (including, if applicable, COBRA coverage), as well as certain additional information required by law. This certificate may be necessary if you and/or your dependent(s) become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered dependents a health insurance policy within 63 days after your coverage under this Plan ends. The certificate is necessary because it may reduce any exclusion for pre-existing conditions that may apply to you and/or your covered dependents under the new group health plan or health insurance policy.

This certificate will be provided to you shortly after this Plan knows, or has reason to know, that coverage (including COBRA coverage for you and/or your covered dependent(s)) has ended. This certificate will also be provided once the Fund Office receives a request for this certificate, provided that the Fund Office receives the request within two years after the later of the date your coverage under this Plan ended or the date your COBRA coverage ended.

The certificate will be sent to you (or to any of your covered dependents) by first class mail shortly after your or their coverage under this Plan ends. If you (or any of your covered dependents) elect COBRA coverage, another certificate will be sent to you (or them if COBRA coverage is provided only to them) by first class mail shortly after the COBRA coverage ends for any reasons.

Please address all requests for certificates of creditable coverage to:  
Anthony D'Amico  
Metal Lathers Local 46 Welfare Trust Fund  
260 East 78<sup>th</sup> Street  
New York, NY 10021  
(212) 535-2323

### **While You are Disabled**

If you are unable to work at least 900 hours in a calendar year because you are disabled, *and* you are receiving accident and sickness benefits from this Fund, or Workers' Compensation benefits, you can continue to receive credit toward continued coverage. Each month in which you are disabled and receiving benefits, you will be credited the same average number of hours you worked during the six months before you became disabled, for a total of six months.

### **Can you continue coverage after termination?**

If your coverage terminates, you may be eligible for self-pay COBRA continuation coverage.

### **Accident and Sickness Benefits**

There are special provisions relating to your accident and sickness benefits.

Your coverage will continue unless you fail to do work for any contributing employer during a period of eight consecutive weeks. However, if during this time you do any work for which you are paid, your accident and sickness benefits will end on:

- the first day you work for an employer who is subject to the New York Disability Benefits Law; or
- the sixth day you work for an employer who is not subject to the law.

Your accident and sickness benefits will also end if the policy is cancelled or if your employer is no longer a contributing employer.

### **CAN YOU CONVERT YOUR COVERAGE?**

If your coverage ends for any reason, you can convert *some* of your group policies to individual policies. The following can be converted:

- G.H.I
- Life Insurance

These converted policies are not identical to the coverage you have as part of this group. See the description of each coverage to find out how to convert to individual policies.

## **HOW DO YOU FILE CLAIMS?**

There are different claims procedures for each of the different types of coverage. Please see the description of each coverage to find out how to file claims.

## **COORDINATION OF BENEFITS**

### **How Coordination of Benefits Works**

Coordination of Benefits (COB) prevents duplication of benefit payments when Fund participants and/or their eligible dependents have coverage under more than one group plan or program. For example, if you and your spouse each have group health plans at work, and you cover each other and both plans cover your children, the coordination of benefits feature determines which plan pays benefits first for you (your primary coverage) and which plan pays benefits first for your eligible dependents, when you and/or they receive treatment.

### **How Benefits Are Paid When There Is Other Coverage**

#### Coverage for You

- If both plans have a COB feature, the Plan that insures you as an active employee pays first.
- If you are insured as an active employee under both plans, the Plan that has insured you longer pays first.

#### Coverage for Your Spouse

The plan provided by his or her employer pays first.

#### Coverage for Your Children

The “birthday rule” determines which plan pays first:

- The plan covering the spouse whose birthday falls earlier in the year will pay first for the children.
- If you and your spouse have the same birthday, the plan covering you or your spouse for the longer period of time pays first.
- If the other plan doesn’t have the birthday rule, the father’s plan pays first.

In cases of divorce or separation, the plan of the parent with child custody pays first. If the parent with custody remarries, the order of payment is as follows:

1. The plan of the natural parent with whom the child resides pays first.

2. The plan of the stepparent with whom the child resides pays second.
3. The plan of the natural parent who does not have child custody pays last.

Notwithstanding the above rules, if a divorce decree orders one parent to be financially responsible for the dependent child's medical expenses, the benefits of a plan which covers the child as dependent of the parent with such financial responsibility will be determined before the benefits of any other plan which covers the child as dependent. In addition, the Plan will cover a dependent child under any order that it determines to be a Qualified Medical Child Support Order (QMCSO). (For more information on QMCSOs, see pages 4-5.)

### **Coordination of Care for Active Employees Age 65 and Older (Medicare)**

Once you reach age 65, you are eligible for Medicare benefits, even if you are still working. You can delay your enrollment in Medicare until you retire. However, it may be to your advantage to sign up for Medicare when you first become eligible at age 65, since Medicare coverage would be available to you during periods of unemployment. You must apply for Medicare at your local Social Security office at least three months before you reach age 65 to have your coverage become effective when you reach age 65.

If you enroll in Medicare as an active employee, you may choose whether Medicare or the Metal Lathers Local 46 Welfare Trust Fund will be your primary insurer. If you elect the Metal Lathers Local 46 Welfare Trust Fund as your primary insurer, this Plan will pay benefits first and Medicare will pay second. If you elect the Metal Lathers Local 46 Welfare Trust Fund as your primary insurer, you and your covered spouse age 65 or older will have the same coverage as any other active employee and covered spouse as long as you remain eligible under the Fund's eligibility rules.

If, however, you elect Medicare as your primary insurer, by law, your Metal Lathers Local 46 Welfare Trust Fund coverage must end.

### **Medicare Coverage Explained**

Medicare traditionally has consisted of two parts:

- Part A, which provides hospital benefits.
- Part B, which provides medical benefits.

Part A is provided at no cost to you; Part B has a monthly premium (\$50.00 for 2000).

On January 1, 1999, Medicare Part C was introduced. Part C includes a choice of managed care plans (including HMO coverage); as well as medical savings accounts combined with high-deductible medical plans and other coverage options. For Part C coverage, you must pay the Part B premium, plus, in some instances, depending on the plan chosen, an additional premium amount.

### **Medicare Coverage for Disability**

If you are under age 65, disabled, and become entitled to Medicare benefits, Medicare provides your primary coverage and the Plan provides your secondary coverage for a period of two years from the onset of disability.

### **Medicare Coverage for Disability Due to End-Stage Renal Disease**

- For the first 30 months of disability, the Fund provides your primary coverage and Medicare provides secondary coverage.
- After the first 30 months of disability, Medicare provides your primary coverage and the Fund provides your secondary coverage. Medicare will begin benefit payments three months after the onset of end-stage renal disease.

### **Coordination with Medicaid**

If your eligible dependent(s) have coverage under both the Fund and Medicaid, the Fund will provide primary coverage.

### **Coordination with CHAMPUS**

If both the Metal Lathers Local 46 Welfare Trust Fund and CHAMPUS cover you and/or your dependent(s), this Plan is your primary insurer, and CHAMPUS pays secondary.

### **Coordination with Veterans Affairs Facility Services**

You and/or your dependent(s) will not receive any benefits from this Plan if a covered individual receives health care services in a U. S. Department of Veterans Affairs hospital or facility on account of a military service-related illness or injury.

### **Other Coverage Provided by State or Federal Law**

If you and/or your dependent(s) are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first, and this Plan pays second.

### **Coordination with Workers' Compensation**

If you are receiving benefits for a particular condition through Workers' Compensation insurance or a similar program, Workers' Compensation provides your primary and only coverage for that particular condition. Your Plan coverage is still in effect, excluding coverage for the particular condition that warranted Workers' Compensation benefits.

### **In the Case of Subrogation**

If another person or entity inflicts illness or injury on you or your dependent(s), the Fund will pay for your or your dependents' health care needs. If you receive a settlement, judgment, or other compensation from the person or entity that caused the injury or illness, the Fund is entitled to the amount it paid for your or your dependents' benefits.

### **Motor Vehicle No-Fault Coverage Required by Law**

In addition to the COB provision described above, many states have laws that are commonly called "No-Fault Automobile Insurance Laws." If you live in a state that has such a law, you may receive medical expense benefits from your automobile insurance carrier if you are involved in an accident involving a motor vehicle. The medical benefits you receive from the No-Fault Law will be taken into account to determine your benefits under this group plan. To do this, and keep your out-of-pocket medical expenses to a minimum, the No-Fault insurance will be considered a separate plan.

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## HEALTH BENEFITS

Your health benefits are provided through an insurance carrier. G.H.I. provides both hospital benefits and comprehensive medical benefits. All hospitalizations - with the exception of certain pregnancy-related hospitalizations - must be pre-certified by GHI. In addition, certain surgeries and certain other services must be pre-certified by GHI. If you fail to pre-certify these services, the Plan will reduce your benefits. See pages 11, 14-16 for more details.

If you have access to the internet, you can log on to [www.ghi.com](http://www.ghi.com) to help get up to date information on GHI, participating hospitals, doctors and other providers and other helpful information. You can also contact GHI customer service through the Internet website.

### **G.H.I. HOSPITAL BENEFITS**

Your hospital benefits are provided through G.H.I.

### **WHAT YOUR BENEFITS ARE**

If you or your eligible dependents stay in an in-network Hospital, you are covered in full for 365 days, provided your stay has been pre-certified. Please see the following page for more details. Certain pregnancy-related stays may not require pre-certification.

Hospital Insurance

### **HOW BENEFITS ARE PROVIDED**

Whenever you or one of your eligible dependents receive hospital services, simply present your GHI Hospital Insurance Identification Card to the hospital. In most instances, claim forms are sent directly from the hospital to GHI. In those cases where the hospital does not bill GHI, you must submit a claim directly to GHI. When your claim has been processed, you will receive an Explanation of Benefits statement.

Whenever you or one of your eligible dependents receive medical services from a GHI participating provider, simply present your GHI Medical Plan Identification Card to the provider. You must verify that the provider is a participating provider before services are rendered. The GHI participating provider will bill GHI directly for covered services. If you

or one of your eligible dependents receive medical services from a nonparticipating provider, you must pay the provider and then file a claim with GHI.

## 365 – Day Hospital Plan

The GHI 365 – Day Hospital Plan provides benefits and services that include hospital room and board, general nursing care, emergency care and pre-admission testing, as well as home care, dialysis for kidney failure, in and outpatient treatment for alcoholism and substance abuse, hospice care, radiation therapy, and chemotherapy.

**Pre-certification** is required for *all* hospital admissions. Failure to comply with requirements of pre-certification will result in a \$250 maximum penalty. Pregnancy-related stays not exceeding 48 hours for a vaginal delivery or 96 hours for a Caesarian section don't require pre-certification.

### **PREADMISSION CERTIFICATION PROVISION**

Before entering the hospital (or within 2 business days in the case of an emergency admission), you or your doctor must contact the GHI Coordinated Care Department to pre-certify admission. The toll-free telephone number is 1-800-223-9870. The number appears on the back of your GHI Hospital Identification Card.

If you contact the service personally, please have your attending physician's name and telephone number available so the pre-certification service can contact the physician's office. You are ultimately responsible to ensure that the pre-certification requirement has been satisfied.

Using recognized medical standards, the pre-certification service examines the appropriateness of your hospitalization. After making this review, they will send a letter with all appropriate hospital information to your attending physician, the hospital, and to you.

After you enter the hospital, the Coordinated Care Department will be in contact with the hospital and your attending physician to follow your progress.

The pre-admission certification process does not guarantee or assure that the hospital admission is covered under the plan of benefits. Please read the coverage provisions carefully. All exclusions and benefit limitations apply. Remember, you must call 1-800-223-9870 in connection with all hospital admissions, with the exception of certain pregnancy-related admissions describe above.

## **BENEFIT PERIOD**

Coverage is provided for 365 days in each benefit period. The benefit period begins when the patient is admitted to a hospital. At least 90 days must elapse for a new benefit period of 365 days to begin. (If the patient is readmitted before 90 days have elapsed, the number of days in the confinement are counted toward the benefit period of the first admission.)

A new benefit period begins whenever the patient is admitted to a hospital for an accidental injury, even if 90 days have not elapsed since prior discharge.

## **LARGE CASE MANAGEMENT**

Large Case Management focuses on catastrophic illnesses. The management process begins when cases are referred to the program. This can occur in a number of ways. Large cases can be identified during the hospital pre-admission screening process when subscribers call to receive authorization for non-emergency hospital confinements, or they can be referred by the Group. Large cases can also be identified through GHI's "expert" computer system, which scans the hospital and medical system to flag potential referrals that are reviewed and acted upon by the case managers.

Conditions and injuries that are frequently identified by Large Case Management include cancer, major trauma, AIDS, high-risk infants and pregnancies, infectious disease, diabetes, psychiatric disorder, organ transplants, and spinal injuries. The case manager acts as a liaison between the patient's family physician and medical facilities. The case manager also assesses the case and identifies alternate treatment plans when appropriate. Often, options include rehabilitation hospitals, hospices, home health care, or special therapy programs, utilized in a way that maintains quality of care for the patients and maximizes benefits, while minimizing cost. The final decisions on care remain with patient and the physician.

## **COVERED INPATIENT BENEFITS**

GHI provides 365 days of coverage for hospital services in each benefit period. This coverage is available in general acute care hospitals. Among the many hospital services covered are the following:

- Semi-private room and board including special diet and nutritional therapy;
- General and special nursing care other than private-duty nursing;
- Use of operating and recovery rooms and equipment;
- Use of intensive care or special care units and equipment;
- Oxygen and other inhalation therapeutic services and supplies;

- Approved drugs and medications for use in the hospital;
- Blood, services, supplies and equipment related to the administration of blood, blood products, and blood derivatives.
- Services, supplies, and equipment related to X-rays, laboratory, pathological examinations, radiation and nuclear therapy;
- Diagnostics studies during a covered hospital stay;
- Facilities, services, supplies, and equipment related to surgical operations, recovery facilities, and anesthesia;
- Facilities, services, supplies, and equipment related to physical and occupational therapy and rehabilitation;
- Facilities, services, supplies, and equipment related to radiation therapy, nuclear therapy, and rehabilitation;
- Sera, biologicals, vaccines, intravenous preparations, and materials for diagnostic studies.

## **INPATIENT SUBSTANCE ABUSE CARE**

GHI has a preferred provider organization network for the treatment of alcoholism and substance abuse. Inpatient services are paid in full, but must be provided by a participating facility. The facility must also be designated by GHI as a network facility for the type of treatment that you require. You must pre-certify your hospital admission with GHI's Coordinated Care Department at 1-800-223-9870. To submit a letter to GHI's Coordinated Care Department write to:

GHI Coordinated Care  
P.O. Box 2809  
New York, NY 10116

GHI pays the hospital directly; there is no out-of-pocket cost to you for covered services.

- Chemical Dependency Treatment, De-Tox (7 days per calendar year);
- Rehabilitation (30 days per calendar year), maximum of two confinements per lifetime.

## **MANDATORY SECOND SURGICAL OPINION**

*Second Surgical Opinion* – To assure that medical decisions are appropriate and made in your best interest, GHI encourages you to obtain a second opinion before undergoing elective, non-emergency surgery. *(For certain procedures a Second Surgical Option is required in order to avoid penalty. See below)*

If surgery involves any of the procedures listed below, you *must* arrange for a second opinion (or third opinion, if you choose, because the first two differ), by calling GHI Coordinated Care at (212) 615-4662 or (800) 223-9870. The second opinion consultant is paid directly by GHI. You incur no expense for this service. The procedures are:

- Back surgery  
(limited to disc surgery, including disc injection therapy, laminectomy and/or spinal fusion)
- Breast surgery  
(simple, radical, modified radical and partial mastectomy)
- Cataract surgery  
(with or without lens implant)
- Carotid endarterectomy
- Gallbladder surgery  
(limited to removal of gallbladder for stones)
- Heart bypass surgery
- Hip surgery  
(total replacement)
- Hysterectomy  
(removal of uterus with or without removal of tubes and ovaries)
- Knee surgery  
(arthroscopy, arthrotomy, meniscectomy, synovectomy and total replacement)
- Nose surgery  
(deviated septum, non-cosmetic rhinoplasty and submucous resection)
- Prostatectomy  
(partial or total removal of a prostate gland)
- Tonsillectomy/adenoidectomy
- Varicose vein removal/stripping

## **IF YOU FAIL TO CALL COORDINATED CARE:**

Failure to comply with the Pre-certification or Second Surgical Opinion requirements will result in the following benefit reductions:

In the event you do not call to pre-certify your hospital confinement, the hospital benefit will be reduced by \$125 per day, up to a maximum of \$250 per confinement.

If one of the procedures requiring a Second Surgical Opinion is performed without obtaining a second opinion, the surgical allowance will be reduced by 50% or \$500, whichever is less. The subscriber is responsible for the difference between the GHI payment and the charge.

Only one Managed Care benefit reduction will be applied. If you do not comply with these requirements, your benefit reduction will be applied to either hospital charges or physicians' charges, but not both.

## **Newborn Care/Maternity Coverage**

Starting with the 1998 plan year, health plans that provide maternity coverage must allow new mothers and their infants to stay in the hospital at least 48 hours after a vaginal birth and 96 hours after a Caesarian section. While the Metal Lathers Local 46 Welfare Trust Fund does not currently restrict hospital stays to less than these time frames, the following statement is provided in accordance with the law:

This Welfare Fund complies with federal law that prohibits restricting benefits for a mother or newborn child for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarian section. The law also prohibits a plan from requiring a health care practitioner to obtain authorization from the Fund for prescribing a length of stay **not** in excess of those periods. However, Federal law generally does not prohibit the mother's or newborn's health care practitioner, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours, as applicable).

## COVERED HOSPITAL OUTPATIENT BENEFITS

GHI covers the following outpatient services in general acute care hospitals:

- ***Emergency Care:*** When provided for sudden and serious medical or behavioral condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:
  - Placing the health of the person afflicted with such condition in serious jeopardy or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
  - Serious impairment to such person's bodily functions;
  - Serious dysfunction of any bodily organ or part of such person; or
  - Serious disfigurement of such person
- If a physician is not employed by the hospital and bills separately for his professional services in connection with a covered outpatient service, this charge may be covered only under the medical portion of the Plan.
- ***Facilities Relating to Minor Surgery:*** Use of hospital surgical facilities.
- ***Presurgical Testing:*** Diagnostic tests necessary for your treatment when ordered by a physician as a planned preliminary to your scheduled surgery in the same hospital, when performed within 7 days prior to the surgery.
- ***Chemotherapy:*** Benefits for non-experimental cancer chemotherapy (including medications), upon referral.
- ***Dialysis:*** When provided in a hospital-based or freestanding facility, dialysis is covered if the program is approved by the appropriate governmental authorities. In the home, appropriate and necessary supplies required for home dialysis, as well as equipment rental, are covered.
- ***Radiation Therapy:*** Radiation therapy for diagnostic purposes is covered, including the use of isotopes, upon referral.
- ***Mammography Screening:***
  - Single baseline mammogram for persons 35 through 39 years of age;
  - Mammogram every two years, or more frequently upon the recommendation of a physician, for persons 40 through 49 years of age;
  - Annual mammogram for persons 50 years of age and older.

- At any time, upon the recommendation of a physician, if the patient, patient's sibling or either parent has a history of breast cancer.
- **Pap Smears:** An annual pap smear and pelvic examination are covered for women who are 18 years of age or older.

### **Physical Therapy**

If you're hospitalized primarily for physical therapy and rehabilitation, you can receive regular hospital benefits for up to 30 days per calendar year. This care must be provided under a program approved by the New York State Department of Health.

**Mental or Nervous Disorders:** Benefits are provided for inpatient psychiatric care for up to 30 days per calendar year in a non-governmental general acute care hospital which is a GHI participating private psychiatric hospital. Care in other facilities is not covered. You must pre-certify your hospital admission for inpatient psychiatric care.

### **Outpatient Benefits**

**Outpatient Alcoholism and Substance Abuse Treatment:** Subscribers are covered in full for 60 outpatient visits per calendar year for the diagnosis and treatment of alcoholism and/or substance abuse in an approved facility. Under a family contract, up to 20 of these 60 visits will be covered for family therapy, even if the person with the alcohol or substance abuse problem is not receiving treatment.

### **HOME CARE**

GHI covers up to 40 days of home care per calendar year. You must have a physician-approved treatment plan. The services must be rendered through a certified Home Health Agency with an Operating Certificate issued under Article 36 of the New York State Public Health law. Benefits will be provided *only* if hospitalization or confinement in a hospital or skilled nursing facility would otherwise have been required.

### **HOSPICE CARE**

You are covered for hospice care. Your coverage includes services provided by the hospice organization, such as drugs and medical supplies in your home, a hospital center or a hospital. You are eligible for 210 days of hospice care per lifetime. Five visits are available for bereavement counseling services for the family at any time. To obtain benefits, you must experience an illness for which the attending physician's prognosis for life expectancy is estimated to be six months or less. The service must be rendered by a hospice organization authorized to operate pursuant to Article 40 of the Public Health Law by the New York State Department of Health or similar state agency in other states.

You are covered in full for services rendered by a participating hospice organization. Typically, covered hospice and outpatient services include: bed patient care, either in a designated hospice unit or in a regular hospital bed, and day care services provided by the hospice organization.

Home care and outpatient services provided by the hospice and charged to you by the hospice are also covered.

## **GHI CENTERS OF SPECIALIZED CARE**

*Providing Access to Specialized Care for Cardiac Surgery, Bone Marrow and Organ Transplant Procedures*

While any surgery is reason for concern, highly specialized procedures, such as *cardiac surgeries, bone marrow and organ transplant procedures*, require highly advanced medical treatment, and involve critical medical and personal considerations for patients and their family members.

Fortunately, most people will never need this specialized form of care. However, should such care be necessary, GHI has developed a network of recognized medical facilities designed to offer subscribers access to quality care with the opportunity to receive paid-in-full benefits for covered specialized services that would otherwise result in significant out-of-pocket expenses.

The GHI Centers of Specialized Care is a network of institutions recognized for their expertise in a broad range of cardiac care, bone marrow and organ transplant procedures. The GHI Centers of Specialized Care network also offers support services that can assist you and your family before and after treatment.

<p style="text-align: center;"><b>GHI CENTERS OF SPECIALIZED CARE NETWORK</b></p>
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Only a limited number of hospitals are licensed to handle these highly complex procedures. GHI Centers of Specialized Care are among the leaders in their respective specialties.

Each hospital undergoes an evaluation process before inclusion in the GHI Centers of Specialized Care network. Hospitals are reviewed according to many criteria, including:

***Favorable Clinical Outcomes and Patient Satisfaction***

Medical facilities in the GHI Centers of Specialized Care network perform a substantial number of specialized procedures each year, and have achieved a recognized level of successful clinical outcomes and favorable long-term survival rates. Moreover, these hospitals have received favorable patient satisfaction reports.

***Qualified Physicians and Nursing Staff***

GHI Centers of Specialized Care offer Board-certified specialists and staff assistants with specialized training and experience to perform the surgical procedures.

***Sophisticated Medical Technology***

Hospitals in the GHI Centers of Specialized Care network utilize advanced medical and surgical technology, including the most sophisticated surgical equipment and monitoring devices.

***Academic Recognition and Research Efforts***

Hospitals within the GHI Centers of Specialized Care network are leaders in medical research and act as teaching hospitals in affiliation with academic institutions. Through these efforts, physicians and hospital staff are knowledgeable about ongoing advances in cardiac care, bone marrow, and organ transplant technology.

**HEALTH BENEFITS IMPACT**

Hospitals and physicians participating in the GHI Centers of Specialized Care network have agreed to accept GHI’s reimbursement as payment-in-full for covered cardiac care, and covered heart, liver, kidney, heart/lung, and bone marrow transplants.

Therefore, when you select a hospital from the GHI Centers of Specialized Care network, you incur no out-of-pocket expenses for covered cardiac care, bone marrow and organ transplant services.

As with all other covered services, you have the freedom to choose any provider. If you elect to receive services provided outside of the GHI Centers of Specialized Care network, your care will be subject to any applicable deductibles, coinsurance and maximums associated with your GHI Health Plan.

In-hospital medical care *other than* cardiac, bone marrow or organ transplant services provided to you in a hospital participating in the Centers of Specialized Care program will be covered under your standard GHI Health Plan and subject to applicable deductibles, co-insurance and maximums. They are *not* covered as part of the GHI Centers of Specialized Care program. All admissions under the Centers of Specialized Care program must be pre-certified by GHI.

The Center of Specialized Care program is available only to GHI subscribers who are active employees, non-Medicare eligible retirees, and their covered dependents. Coverage under this benefit is provided only when GHI is the primary insurance carrier.

**HOW TO ACCESS THE GHI CENTERS OF SPECIALIZED CARE NETWORK**

As a GHI subscriber, you must first call GHI’s Coordinated Care Department at 212-615-4662 or, outside the New York City area, 800-223-9870 before any hospital admission, regardless of the type of treatment or diagnosis. As only certain cardiac services, bone marrow, and organ transplants are covered through the Centers of Specialized Care network, it is important that you call GHI’s Coordinated Care Department as soon as possible prior to

your hospital admission. Call at least 10 days before a scheduled hospital admission in order to maximize your insurance benefits and avoid penalties.

For example:

- If cardiac surgery may be necessary and you are referred to a cardiologist for cardiac catheterization or other tests, call GHI's Coordinated Care Department if you wish to have your tests provided through the network.
- If cardiac surgery or a bone marrow or an organ transplant is found to be necessary, and your physician refers you to a surgeon, call GHI's Coordinated Care Department if you wish to have your surgery provided through the network.

If you are the recipient patient for a bone marrow transplant or an organ transplant and you live more than 75 miles from a network hospital, you may be eligible for travel expenses up to \$150 per person per day. This reimbursement includes food and lodging of the recipient patient and one adult family member (two, if the recipient is a minor).

<p style="text-align: center;"><b>A SOURCE OF PRE- AND POST-SURGICAL SUPPORT</b></p>
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Once GHI confirms the medical necessity of specialized care, a Nurse Consultant will be assigned to your case. The Nurse Consultant – a Registered Nurse in GHI's Managed Care Department – will provide you and your physician with information on the resources available through GHI Centers of Specialized Care.

Your proposed treatment plan is pre-certified through GHI's Coordinated Care Department. The pre-certification process verifies the appropriateness and medical necessity of services before you are admitted to the hospital. The Coordinated Care Department also performs a concurrent review during your hospital stay to track your progress and assess the appropriate length of your hospital stay. The GHI Nurse Consultant utilizes concurrent review findings to help you receive the appropriate level of care throughout your hospital stay and to coordinate the appropriate discharge planning arrangements, which may include home care, rehabilitation services, and referral to community service organizations.

## Medical Insurance

### Comprehensive Benefits Plan (CBP) With Extended Medical Coverage

The GHI Medical Plan works in two ways. The Comprehensive Benefits Plan (CBP) provides paid-in-full benefits (except for applicable co-payment charges) for covered medical services when you use a GHI participating provider. Covered services rendered by non-participating providers are reimbursed subject to extended medical provisions, i.e. deductible, coinsurance, and maximums. The following explains your benefits in more detail. The decision to use a participating or non-participating provider is up to you for most covered services.

#### **WHEN YOU CHOOSE A PARTICIPATING PROVIDER**

If you use a GHI participating provider for your medical care, you pay a \$10.00 copayment for each home or office visit. You incur no additional out-of-pocket expense for covered medical services. Participating providers have agreed to accept GHI's allowances as payment-in-full for covered services. Payment is made directly to the GHI participating provider. Benefits provided through participating providers are not subject to deductibles or maximums.

#### **WHEN YOU CHOOSE A NON-PARTICIPATING PROVIDER**

When you choose a non-participating provider, payment is made directly to you under the Extended Medical/Surgical program. Reimbursement is made at 80% of the allowed charge (80<sup>th</sup> percentile of Health Insurance Association of America's (HIAA) schedule, subject to an annual deductible of \$500.00 per individual and \$1,000.00 per family. After you have met your annual deductible, GHI will pay 80% of the first \$5,000 of eligible expenses. When you incur \$1,000 in co-insurance expenses per person in a given calendar year, you will no longer be subject to a co-insurance charge. GHI will then pay 100% of the allowed charge as determined by GHI. There is a lifetime maximum of \$1 million per person.

#### **COVERED MEDICAL SERVICES**

The following services are covered under the GHI Comprehensive Benefits Plan and the Extended Medical Plan. The following benefits are covered for both participating and non-participating providers unless indicated otherwise:

### **In-Hospital**

- Surgery
- Surgical assistants
- Administration of anesthesia
- Hospital visits
- Intensive care
- Specialist consultations
- Care of premature infants
- Psychiatric care
- Shock therapy
- Maternity care
- Newborn care
- Radiation therapy

### **Out-of-Hospital**

- Office visits
- Home calls
- Chemotherapy
- Diagnostic X-ray and laboratory examinations
- Pre-and post-natal care surgery
- Surgery
- Surgical assistants
- Administration of anesthesia

- Allergy care (16 visits per calendar year - \$10 copay per visit in-network)
- Speech therapy (16 visits per calendar year - \$10 copay per visit in-network)
- Routine podiatric care (maximum of 4 visits per calendar year- \$10 copay per visit in-network)
- Mammography screening
- Chiropractic care (\$10 copay per visit in-network)
- Physical and occupational therapy (16 visits per calendar year- \$10 copay per visit in-network)
- Specialist consultations
- Radiation therapy
- Shock therapy
- Visiting nurse service
- Diabetes management
- Annual physical checkup, only when rendered by a participating provider
- Ambulance Services – This benefit is not available as a paid-in-full benefit through participating providers. GHI will pay you up to \$100 for covered ambulance trips under 50 miles and \$125 for covered ambulance trips of 50 or more miles. You are not covered for ambulette service. Air ambulance is also not covered.
- Home Infusion therapy

**Medical Coverage – Preventive Care**

- Annual Physical Check-up (in network \$10 co-payment; out of network not covered)
- Well baby care
- Well child care
- Pediatric immunizing agent
- Well woman care, which includes PAP smear screening and mammography screening

- Prostate screening (in network \$10 co-payment)

### **Women's Health and Cancer Rights**

The Women's Health and Cancer Rights Act of 1998 provides certain reconstructive surgery benefits for women who have had a mastectomy.

All group health plans, insurers, and HMO's that provide medical and surgical benefits in connection with a mastectomy must provide the following benefits, in a manner determined in consultation with the attending physician and the patient, for reconstructive surgery:

- Reconstruction on the breast on which the mastectomy was performed;
- Surgery on the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications in all stages of the mastectomy, including lymphedemas.

This coverage is subject to any applicable Plan copayments, referral requirements, annual deductibles, and coinsurance provisions.

# ***RADIOLOGY PRE-CERTIFICATION PROGRAM***

## ***IMAGING PROCEDURES REQUIRING PRE-CERTIFICATION***

- Computerized Axial Tomography (CT Scan)
- Magnetic Resonance Imaging (MRI)
- Sonograms (Ultrasound)
  - Abdominal
  - Pregnant Uterus
  - Fetal Echocardiography
  - Transrectal
  - Extremities
- Cardiovascular System
  - Myocardial Perfusion
  - Myocardial Imaging
  - Cardiac Imaging
- Non-Invasive Vascular Studies
  - Cerebrovascular Arterial
  - Extremity, Arterial
  - Extremity, Venous
- Echocardiography

### ***Important Phone Number***

For Pre-Certification (NYMI): 1 (800) 835-7064

### **GHI Professional Relations Contacts:**

**Your Doctor and Radiologist Must Obtain Pre-Certification.** It is essential that your doctor obtain pre certification for these radiological services. It is in your best interest to encourage your referring doctor to pre-certify these services and have them performed through the expanded radiological GHI network. The network is required to work with your physician to pre-certify these high-tech radiology services. **Should the referring physician fail to pre-certify services the ultimate responsibility for pre-certifying rests with the provider performing the radiological service.**

## **GHI Podiatry Pre-certification Program**

GHI Participating Podiatrists are required to obtain GHI's authorization before performing surgical procedures to treat the following conditions:

- Bunion and Hallux Valgus Deformity
- Morton's Neuroma
- Calcaneal Spur/Plantar Fasciitis
- Hammertoe Deformity
- Haglund's Deformity

By requiring precertification, GHI can help ensure that the surgery is the most appropriate, cost-effective treatment. In this way, you avoid the risk of unnecessary surgeries, and the plan avoids the costs of those surgeries.

### **Providers Responsible for Pre-certification**

GHI Participating Providers, not GHI subscribers, will be responsible for pre-certifying the specified procedures. If a Participating Provider fails to receive pre-certification, GHI will deny payment to the provider, and **the provider will not be permitted to bill the subscriber.**

### **DURABLE MEDICAL EQUIPMENT (DME)**

The DME Preferred Provider Panel provides you with ready access to a wide range of durable medical equipment, such as wheelchairs, hospital beds, etc., which may be required following an accident or illness.

It is to your advantage to use the DME Preferred Provider Panel because it accepts GHI's allowance as payment in full for covered equipment after the annual deductible of \$100 per person has been met. All you need to do is call the DME Panel Provider for your region, or have your representative call for you. **Covered DME obtained outside of the Panel is reimbursed at 50% of GHI's DME allowed charge, subject to the \$100 deductible.**

Certain items which cannot be acquired through the DME Preferred Provider Panel are covered by your plan. They are: mastectomy bras, durable syringes, and certain prosthetic devices.

#### *Items Not Covered by the Plan:*

- splints and casts
- orthotic devices for the feet
- dehumidifiers or other climate control devices

- intra-oral appliances and intra-oral orthopedic devices and their maintenance
- adjustable beds or other beds which are not strictly hospital beds
- over-the-counter items such as antiseptics, gels, bandages and dressings
- any item that is not medically necessary

*GHI's DME Preferred Provider Panel:* The providers and their respective service areas are as follows:

***NEW YORK HOME HEALTH CARE EQUIPMENT:***

(800) 733-0133: Bronx, Dutchess, Kings, Nassau, New Jersey, Orange, Putnam, Queens, Richmond, Rockland, Suffolk and Westchester.

***TRI-STATE RESPIRATORY:***

(800) 637-4423: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk and Westchester

***A & J CARE:***

(718) 326-8000: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk and Westchester.

***HOME CARE SUPPLY:***

(800) 696-1136: Bronx, Kings, Nassau, New York, Orange, Queens, Rockland, Suffolk and Westchester

***K & R HOME MEDICAL:***

(914) 963-7070: Bronx, Kings, Nassau, New York, Orange, Queens, Rockland and Suffolk

***LOW SURGICAL MEDICAL:***

(718) 445-3187: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester

## **PRIVATE DUTY PROFESSIONAL NURSING SERVICES**

This benefit is payable under the Extended Medical Benefits plan, subject to deductibles, coinsurance, and a separate annual maximum of \$10,000 per person.

## **DIABETES MANAGEMENT**

- Prescription Drugs – You are covered for insulin, syringes, and oral agents for controlling blood sugar.
- Equipment and Supplies – You are covered for equipment and supplies for the treatment of diabetes. In order to be covered, a provider must recommend or prescribe equipment and supplies. The provider must be authorized to write a prescription. You are covered for: blood glucose monitors, data management systems, injection aids, cartridges for legally blind, insulin pumps, and insulin infusion devices. The items listed above are covered in full if you obtain them from a GHI Durable Medical Equipment (DME) Preferred Provider. If you obtain these items from a non-participating DME provider, they are covered subject to the coinsurance and maximums for this plan.
- Education – You are covered for diabetes management education to ensure that you are informed of the proper self-management treatment of your diabetic condition. This includes education relating to proper diet.

## **HEMODIALYSIS**

- *Dialysis*: When provided in a hospital-based or freestanding facility, dialysis is covered if the program is approved by the appropriate governmental authorities. In the home, appropriate and necessary supplies required for home dialysis, as well as equipment rental, are covered.

## **WHAT IS NOT COVERED UNDER GHI HOSPITAL BENEFITS**

Your GHI Plan does *not* cover

- expenses caused by a job-related accident or illness covered under Workers' Compensation or a similar law;
- hospitalization furnished under federal, state or other laws, or in a veterans' facility or a hospital operated by the United States government;
- confinement for sanitarium-type, custodial or convalescent care, or for rest cures;
- stays in a hospital for long-term care;

- hospital confinement primarily for diagnostic studies;
- services of physicians, or private or special nurses, or other private attendants, or their board;
- stays in a hospital or services furnished which are covered in full under no-fault automobile insurance laws;
- Inpatient Substance Abuse in a non-participating GHI facility;
- care in an institution which does not routinely bill and collect charges from patients;
- members of this Plan who are eligible for Medicare (except as described on page 38);
- care that is not medically necessary. In general, any health care service that GHI, in its sole judgment, determines is not medically necessary will not be covered by GHI. If an external appeal agent certified by the State of New York overturns GHI's denial, however, GHI shall cover the procedure, treatment, service, pharmaceutical product, or durable medical equipment for which coverage had been denied to the extent that such a procedure, treatment, service, pharmaceutical product, or durable medical equipment is otherwise covered under the terms of the plan;
- charges that exceed reasonable and customary amounts. Determination of reasonable and customary is made by GHI.

## **TERMINATION AND CONVERSION**

Your coverage ends as described on page 6. However, you can convert to an individual policy if you ask for an application form from the Fund Office, complete it, and return it to GHI within 30 days after your group coverage ends.

Coverage for your dependents ends as described on page 6. When your children are no longer eligible for benefits under this group coverage, they can convert to an individual policy.

Premium rates and the type of coverage may not be the same as the coverage you had under your group plan.

This is not the same as COBRA coverage which you may also be eligible for.

## **CLAIMS APPEAL PROCEDURE**

All claim forms received by GHI are screened for completeness, medically coded, numbered, registered, and checked for eligibility. Submitted claims are then reviewed for coverage and an approval or rejection of benefits is made.

If you disagree with the disposition of a claim, you may request a review. You, or your duly authorized representative, must make the request in writing (Attention: Claims Appeals) within 60 days of notification from GHI of the disposition of your claim to:

Group Health Inc.  
Attn: Claims Appeals  
441 9<sup>th</sup> Avenue  
New York, NY 10001

Be sure to include your current identification number and the claim number, as well as any pertinent information or comments you wish to make. Upon receipt of the request for review, the claim will then be reconsidered, taking into account any additional information you have provided. Upon completion of this review, you will receive written notification of the decision explaining the original disposition for the claim or the basis for upholding the claim.

## PRESCRIPTION PROGRAM

1. **Using Your GHI/PAID Prescription Card:** Prescriptions may be obtained through the PAID Prescriptions Coordinated Care Network, which includes over 50,000 TelePAID pharmacies nationwide. These pharmacies are considered “preferred” because they accept reduced amounts as payment in full for covered prescriptions, helping to preserve drug benefits by controlling drug costs.

You can receive up to a 90-day supply of covered medication plus refills as authorized at a local “preferred” TelePAID pharmacy. There is a \$5 copayment for brand medications but no copayment for generic medications, for each 90-day supply received. You can call 1-800-272-PAID to find the TelePAID pharmacy closest to you.

2. **Using Mail Service:** Maintenance prescriptions are available through NRx Services, the mail service drug provider, located in Harrisburg, PA. **The mail service is ideal for those people who take maintenance medications on an ongoing basis for chronic conditions.** You can receive up to a 90-day supply of medications plus refills as authorized. For chronic conditions there is no copayment for both brand and generic medications for each 90-day supply received.
3. **Annual Maximum:** There is an annual per person maximum of \$10,000.

To order mail service medications from NRx Services, you must:

- **Obtain a new prescription** from your physician (up to a 90 day supply plus refills as authorized).
- **Send Prescription(s)** to NRx Services in Harrisburg, PA. Please call NRx at 1-800-445-9707 to obtain an envelope, if you do not have one. Be sure to complete the Drug Interaction Profile, which is included in the brochure that you will receive from Fund office and should be submitted with your order.
- **If you have any questions** regarding your prescriptions, you are encouraged to call NRx Services at 1-800-445-9707.

When you use a non-“preferred” pharmacy, you will be required to pay for the prescription in full and then submit a claim form. Reimbursement to you will be limited to the amount your plan would have paid had you used a “preferred” pharmacy, less any copayment. Therefore, you should use a “preferred” pharmacy whenever possible. To obtain claim forms, call 1-800-272-PAID.

The rising cost of prescription drugs is an area of concern for all of us. We encourage you to save money by taking advantage of this cost effective program, and by using generic medications as well as formulary options whenever possible.

## **TERMINATION AND CONVERSION**

Your coverage ends as explained on page 6. If your major medical coverage ends, you may convert your coverage to an individual policy if you were insured under this group plan for at least three months. This conversion privilege is also available to your covered dependents when you die and when they are no longer eligible for coverage under this group plan.

You must apply for coverage and pay the first premium within 31 days after your group coverage ends. If you would like more information about this individual coverage, contact the Fund Office or G.H.I. The converted policy may not be the same as your group coverage described in this booklet.

## **EXTENSION OF BENEFITS**

Your coverage under G.H.I. may be extended under certain circumstances.

### **Doctor Visits**

If your coverage ends while you or a covered dependent is totally disabled, benefits will be extended for three months to cover visits that result from this disability. The benefits will not be more than the maximum benefit available to you when coverage ended.

### **Surgery**

If your coverage ends while you or a covered dependent is totally disabled, benefits will be extended for three months to cover a surgical procedure that results from this disability.

## **WHAT IS NOT COVERED BY ANY OF YOUR GHI HEALTH COVERAGE**

Your health coverage through GHI will not pay for:

- expenses caused by a job-related accident or illness covered under Workers' Compensation or a similar law;
- expenses for services or supplies provided under any governmental plan or law unless otherwise required by law;
- charges exceeding those usually made when there is no insurance or over the general level of charges in the area;
- expenses for services and supplies provided under any other plan paid for by your employer or the Fund;
- anything not ordered by a doctor;
- services or supplies received as a result of an act of war which occurs while you are covered;
- charges for cosmetic surgery unless due to an accident while you are covered;
- nursing or physical therapy provided by yourself, your spouse, or a child, brother, sister, or parent of yourself or your spouse;
- nutritionists and related services;
- expenses that GHI determines to be related to experimental treatment, investigational treatment, or clinical trials. Experimental treatment is a treatment that has not been tested in human beings, or that is being tested but has not yet been approved for general use, or that is subject to review or approval by an Institutional Review Board. Investigational treatment includes, but is not limited to, services or supplies which are under study or in a clinical trial to evaluate their toxicity, safety, and efficacy for a particular diagnosis or set of indications. Clinical trials include, but are not limited to controlled experiments having a clinical event as an outcome measurement involving persons having a specific disease or health condition, or involve the administration of different study treatments in a parallel treatment design done to evaluate the efficacy and safety of a test treatment. Clinical trials include Phase I, Phase II, and Phase III studies. Clinical trials also include randomized trials or studies.

However, GHI will cover an experimental or investigational treatment approved by an external appeal agent certified by the State of New York. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, GHI will only cover the costs of services required to provide treatment to you according to the design of the trial. GHI will not be responsible for the costs

of investigational drugs or devices, the costs of non-health care services or the costs of managing research. Additionally, GHI will not be responsible for costs which would not be covered under your policy for non-experimental or non-investigational treatments which are provided as a part of a clinical trial.

## **HOW YOU FILE CLAIMS**

*Basic Hospital Benefits* – When you require hospitalization, your doctor makes the arrangements for your admission. Present your GHI Hospital identification card to the hospital admitting clerk.

In most instances, claim forms are sent directly from the institution to GHI. In those few cases where the hospital does not send a notice of claim to GHI, you must submit a claim for yourself directly to GHI.

Remember, in order to be eligible for full benefits, you must pre-certify your hospital admission with GHI Coordinated Care.

*Basic Medical Benefits* – Before receiving care, tell a GHI participating provider that you are a GHI subscriber. You must pay the participating provider the \$10 copayment, if applicable. The participating provider will file a claim form directly with GHI. GHI will make payment directly to the provider except for the copayment, if applicable. If a non-participating provider renders the service, follow the procedure specified below.

*Extended Medical Benefits* – To obtain benefits for covered medical services rendered by non-participating providers, you and your provider must fill out and sign a claim form, available from the Fund office or from GHI, whenever you submit any bills for payment. Before completing the form be sure to read the instructions.

A claim form must always be submitted with bills whenever you file for reimbursement. If only one doctor is involved, complete your portion of the claim and have your doctor complete and sign his or her portion indicating the fee for each service performed. If more than one doctor or more than one patient is involved, a claim form must be filed for each doctor and patient. Simply fill in your part of the forms and attach the original itemized bills. Each bill must indicate the patient's name, date of service, exact service performed, and itemized charges.

If services are performed by a medical professional other than a physician, each bill should include the provider's signature. Nurses' bills must also show the date, place, and hour of duty, and charge per day as well as their signature, status, and registration number.

Always show your certificate number on the claim form exactly as it appears on your Identification Card. All completed hospital claim forms and attached itemized bills should be mailed to:

***GHI***  
***P.O. Box 2833***  
***New York, NY 10116-2833***

File your claim form promptly, but no later than six months after the end of the calendar year in which the service was rendered. If you fail to file your claim on time, GHI may still pay for the service if you show it was not reasonably possible for you to file it on time and you filed it as soon as it was reasonably possible. All completed medical claim forms and attached itemized bills should be mailed to:

***GHI***  
***P.O. Box 2833***  
***New York, NY 10116-2833***

If you receive a notice that your claim has been denied, you may request a review within 60 days after you receive the denial notice. If you do not receive a decision on a claim for benefits within 90 days (or 180 days in special circumstances), you may also request a review of your claim. You or your authorized representative may have the opportunity to review pertinent documents and may submit issues and comments in writing. Requests for a review must be made in writing and should be sent to GHI (Attention: Claims Appeal).

The decision on the review will be made by GHI on any question involving the terms of an insurance contract. The Board of Trustees will make the decision on any other question.

## **RETIREE HEALTH COVERAGE**

If you retire at age 65, your health coverage will continue for one year, provided you have met the eligibility rules for the Trust Fund for the year immediately prior to retirement.

### **Early Retirement**

If you are an active member between the ages of 62 and 65 and you are retiring on an Early Retirement Pension from the Metal Lathers Local 46 Pension Fund, you will continue to receive the benefits provided by the Trust Fund, provided that you have maintained continuous eligibility in the Trust Fund for the two full years immediately prior to retirement. This coverage is also available to your dependent spouse.

This coverage for both the pensioner and spouse will terminate at the end of the month in which the pensioner attains age 65, regardless of the spouse's age. However, if the pensioner's spouse is older, her coverage will terminate at the end of the month she reaches age 65 and the pensioner's coverage will continue until the end of the month he attains 65. If a pensioner covered under this new benefit dies prior to his attaining age 65, his spouse will continue to receive medical coverage for three full months following the month in which the pensioner dies.

Dependent children will not be covered by the Trust Fund upon your retirement.

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## VISION CARE PLAN

Services under this program are administered by Davis Vision.

### **What are the covered vision plan benefits?**

Participation in the plan enables you and your eligible dependents to receive quality vision care services at little or no charge. Covered individuals and eligible dependents are entitled to an eye examination and new lenses or contact lenses once every calendar year, and a new frame once every other calendar year. Standard, soft, daily-wear contact lenses may be selected in lieu of eyeglasses with a \$25.00 copayment paid directly to the participating doctor. A one year breakage warranty is provided for all Plan supplied eyeglasses.

### **Who are the participating doctors?**

They are licensed optometrists located throughout your area who provide quality, comprehensive vision care services and are carefully monitored by Davis Vision's Director of Quality Assurance. Stringent standards have been established for eye examinations and testing equipment.

### **What frames and lenses are included?**

You may select from the assortment of frames in the Fashion selection displayed in the "Davis Fashion Collection" in most participating doctors' offices. Many items are available for selection at a participating provider, at no additional cost to you, including:

- Plastic or glass single vision, bifocal, or trifocal lenses
- Glass grey #3 prescription lenses
- Oversize lenses
- Overdiopter (higher power) lenses
- Post-cataract lenses

Various optional items are also available for selection at a participating doctor with a minimal payment. Please refer to the "Additional Services" section below for more information.

Lenses and frames not available through the Plan may be selected, although additional charges may apply. An allowance from the following schedule will be deducted from the cost:

Lenses	
Single vision	\$14.00
Bifocal	\$23.00
Trifocal	\$32.00
Frame	\$14.00
Contact Lenses	\$45.00

### **Are contact lenses included?**

Standard, soft, daily-wear contact lenses (requiring a \$25.00 copayment) are available through the Plan. A care kit for proper cleaning and sterilization of your lenses will be supplied, as well as all necessary visits for proper fitting. Replacement contact lenses and contact lens insurance are *not* included in the program.

Please note: Contact lenses can be worn by most people, but not by all. Once the contact lens option is selected and the lenses are fitted, they cannot be exchanged for eyeglasses. You may select one pair of contact lenses or one pair of eyeglasses, but not both.

If you need or select contact lenses other than those available through the Plan, a \$45.00 allowance will be applied toward their cost. You are required to pay all additional charges for the contact lenses, fittings, and recommended follow-up care.

## **HOW TO USE YOUR BENEFIT**

### **How do I receive services?**

When seeking vision care services from one of the participating doctors, please call first to schedule an appointment. Be prepared to give the doctor your Social Security number and the year of birth of any dependent children for whom you are requesting services. The doctor is responsible for obtaining the necessary authorization(s). You may also verify your eligibility or locate a participating doctor in your area by calling 1-800-999-5431. You will have 45 days to receive your eye examination after authorization has been received.

When you use a participating doctor, the Plan provides coverage for an eye examination, frame from the "Tower Collection" (Fashion selection), and lenses as previously described.

After scheduling an appointment, if you decide to utilize a different participating doctor, you must first call 1-800-999-5431. To discuss issues regarding Davis Vision providers, please call 1-800-537-2339.

## **ADDITIONAL SERVICES**

The following optional items may be selected at the time you receive services from a participating doctor. The indicated payments should be paid directly to the doctor:

<b>Item</b>	<b>Payment</b>
Designer Frame	\$15.00
Premier Frame	\$35.00
Progressive Addition* Lenses	\$90.00
Blended Invisible Bifocals	\$20.00
Photogrey Extra® Single Vision Lenses	\$20.00
Photogrey Extra® Multifocal Lenses	\$25.00
SuperShield ®Single Vision Lenses	\$20.00
SuperShield ®Multifocal Lenses	\$25.00
Ultraviolet Coating	\$12.00
Reflection Free™ Coating	\$35.00
Polaroid Lenses	\$60.00
Polycarbonate Lenses (no charge for dependent children and monocular members)	\$30.00
High Index Lenses	\$55.00
Transitions ®Lenses	\$65.00

\*Progressive Addition multifocals can be worn by most people, but not by all. Conventional bifocals will be supplied to those unable to adapt to Progressive Addition lenses; however, the charge will not be refunded.

### **Must I use a participating doctor?**

You may receive services from either a participating or non-participating doctor. If you choose to receive services from a non-participating provider, you will be reimbursed according to the following schedule:

Examination	\$25.00
Lenses	
Single Vision	\$20.00
Bifocal	\$30.00
Trifocal	\$40.00
Frame	\$25.00
Contact Lenses	\$55.00

## **Non-participating provider reimbursement**

To receive reimbursement for covered services performed by a non-participating doctor, please submit an itemized receipt along with a completed claim form. Claim forms are available by calling 1-800-999-5431. Please present the claim form to the provider at the time of service and request that the applicable sections be completed. Please sign the form and return it with your receipts to:

*Vision Care Processing Unit  
P.O. Box 2270  
Schenectady, NY 12301*

A check will be sent to your home reimbursing you up to the allowable expense.

## **Are there any restrictions?**

Routine eye examinations and prescription corrective eyewear are included in this program. Benefits not covered under this program include:

- medical treatment of eye disease
- visual therapy
- special lens designs or coatings
- replacement of lost eyewear

## **May I use the benefit at different times?**

All desired services must be obtained at one time from either one participating or one non-participating doctor.

## **What if I have questions or need assistance?**

Your satisfaction is guaranteed. You are encouraged to call 1-800-999-5431 for assistance. A team of specially trained Member Service Representatives are available between 8:00 AM and 8:00 PM, Monday through Friday, and Saturday between 9:00 AM and 4:00 PM, Eastern Time. You may also write to Davis Vision at the address below. All inquiries will be reviewed and responded to within 48 hours of receipt.

Davis Vision  
P.O. Box 971  
Schenectady, NY 12301  
Attn: Quality Management Team

## LOCAL 46 MEMBERS ASSISTANCE PROGRAM

For the Purposes of this Members' Assistance Policy, the terms "troubled member" or "problem member" refer to: a member whose welfare is affected by alcohol abuse, drug abuse, family difficulties, disability, or other problems.

1. The primary purpose of this policy is to aid the alcoholic or otherwise troubled member to recognize the problem and rehabilitate himself or herself to the status of a sober and productive member.
2. Alcoholism is a treatable disease and the alcoholic is an ill person requiring skilled rehabilitative assistance. Otherwise troubled members also require referral to appropriate professionals.
3. The troubled member may be defined as:
  - a) That person whose work performance is impaired by the use of alcoholic beverages or drugs or other negative behaviors which result in recognizable interference with health or interpersonal relationships on the job.
4. The effort to assist the member is accomplished by:
  - a) *Identification* of the problem by Family members or by Self-referral.
  - b) *Self-referrals* are encouraged to participate in the program and are assured of total confidential assistance through referral.
  - c) *Follow-up* on member's progress jointly with aftercare professionals, giving all possible support to the members who cooperate in an honest attempt at recovery.
5. Since Alcoholism is a disease that affects the entire family, efforts will be made to contact and involve family members.
6. It shall be the problem member's responsibility to comply with the Member's Assistance Program and to follow the appropriate resource to which the member is referred.
7. Confidentiality in all aspects of dealing with the member will be strictly observed.

If you need more information about this program, call the Fund Office.

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## ACCIDENT & SICKNESS BENEFITS

This benefit is only available to you if you meet the eligibility requirements described below. Benefits are not available to your dependents.

Accident and sickness benefits are provided by the Fund through the Prudential Insurance Company of America.

### **WHAT YOUR BENEFITS ARE**

If you become totally disabled and unable to work because of an accident or illness off the job, you can receive weekly benefits. Your benefit will be 50% of your average weekly earnings to a maximum benefit of \$170.00.

Your average weekly earnings will be determined by dividing your total earnings during the eight weeks immediately before the date on which you became disabled by the number of weeks you actually worked.

Benefits begin from the first day of disability due to accident and from the eighth day due to illness. Payments continue as long as you are disabled up to maximum of 26 weeks for each disability. Periods of disability caused by the same or related injury or illness are considered the same period of disability if they are separated by less than three months.

You do not have to be confined to your home or the hospital to collect benefits, but you must be under the care of a physician.

Claim forms are available in the Fund Office.

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## LIFE INSURANCE

Term life insurance is available to you from the Fund through the Prudential Insurance Company of America. Your dependents are not eligible for this coverage.

### **WHAT YOUR BENEFIT IS**

If you die from any cause while you are insured, your beneficiary will receive \$30,000. You may name anyone you wish as your beneficiary and you may change your beneficiary at any time by filling out the proper form.

### **If you become totally and permanently disabled**

If you become totally and permanently disabled before age 60, your life insurance coverage will continue without cost to you. *YOU MUST PRESENT PROOF OF YOUR DISABILITY TO THE PRUDENTIAL INSURANCE COMPANY OF AMERICA.*

### **Life Insurance after Retirement**

#### Continuation of Life Insurance Coverage:

If you meet the eligibility requirements stated below, you will receive automatic continuation of your life insurance coverage upon your retirement without cost to you.

#### What Your benefit is:

If you die from any cause while you are insured, your beneficiary will receive \$30,000. You may name anyone you wish as your beneficiary and you may change your beneficiary at any time by filling out the proper form which can be obtained at the Fund Office.

#### Who is eligible?

- If you are an active member with health benefits retiring on an Early Retirement Pension between the ages of 62 and 65;
- If you are an active member retiring on a Regular Pension with health benefits;
- If you are currently receiving retiree health benefits and you attain age 65 during 1997 or thereafter.

## **Termination and Conversion**

If your life insurance coverage ends, you may convert it to an individual policy within 31 days without having to furnish proof of good health.

You may choose one of a number of Prudential individual life policies. The premium cost to you will be based on your age and risk class when you convert.

If you die within the 31-day conversion period, your beneficiary will receive your benefit.

Claim forms are available in the Fund Office.

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## **ACCIDENTAL DEATH & DISMEMBERMENT**

Accidental death and dismemberment coverage is provided for you by the Fund through the Prudential Insurance Company of America. Your dependents are not eligible for this coverage.

### **WHAT YOUR BENEFITS ARE**

If you die or if you lose your limbs or your sight because of an accident on or off the job, you will receive this benefit in addition to your other group insurance benefits.

If you die, your beneficiary will receive \$30,000. Alternatively, if you lose both hands, both feet, or the sight of both eyes, you will receive \$30,000. If you lose one hand, one foot, or the sight of one eye, you will receive \$15,000. The loss must take place within 90 days from the date of the accident.

No more than the full amount (\$30,000) will ever be paid for all losses due to any one accident.

### **WHAT IS NOT COVERED**

You will not receive accidental death and dismemberment benefits if your death or any loss is caused directly or indirectly, wholly or partly, by:

- war, including undeclared war and armed aggression;
- suicide or attempted suicide;
- bodily or mental infirmity or disease;
- infection other than a pyrogenic infection of an accidental cut or wound; or
- travel in any aircraft except as a passenger on a regularly scheduled passenger flight of a commercial aircraft.

### **TERMINATION AND CONVERSION**

This coverage cannot be converted to an individual policy.

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## COBRA CONTINUATION COVERAGE

### COBRA COVERAGE

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), allows you and your eligible dependents to continue health care coverage at your own expense under certain circumstances when health care coverage would otherwise end. Your COBRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Under COBRA, you and your covered dependents may continue the same coverage that you had before the COBRA-qualifying event, including:

- GHI Hospital Benefits
- GHI Comprehensive Medical Benefits
- Prescription Drug Benefits
- Vision Care Benefits

### COBRA Eligibility (COBRA-Qualifying Events)

#### For You

COBRA coverage is available to you if coverage would otherwise end if:

- Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program; or
- Your employment ends for any reason other than gross misconduct.

#### For Your Dependents

COBRA coverage is available to your eligible dependents if coverage would otherwise end if:

- Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program;
- You (the active employee) end employment for any reason other than gross misconduct;
- You (the active employee) die, get divorced, become legally separated, or become entitled to Medicare;
- Your dependent child ceases to be eligible for Fund coverage. For example, he or she marries or reaches the maximum age limit for coverage.

#### How COBRA Coverage Works

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "dependent child" under the Plan, you and/or a family member must notify the Fund Office in writing of that event **no later than 60 days after that event occurs**. That notice should be sent to:

Metal Lathers Local 46 Welfare Trust Fund  
260 East 78<sup>th</sup> Street  
New York, NY 10021

(212) 535-2323

The Fund Office will then send you information about COBRA coverage.

**IF NOTICE IS NOT RECEIVED BY THE END OF THAT 60-DAY PERIOD, THE AFFECTED SPOUSE OR DEPENDENT WILL NOT BE ENTITLED TO CHOOSE COBRA CONTINUATION COVERAGE.**

Your employer will usually notify the Fund Office of your death, termination of employment, reduction in hours, retirement, or entitlement to Medicare. However, you or your family should also notify the Fund Office promptly and in writing if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

The time period in which the employer must notify the Fund of your termination of employment, reduction in hours, death, or Medicare entitlement will begin to run from the date of your loss of coverage rather than the qualifying event date.

### **How to Elect COBRA Continuation Coverage**

When your employment terminates or your hours are reduced so that you are no longer entitled to coverage under the Plan, or when the Fund Office is notified on a timely basis that you died, divorced, or were legally separated, became entitled to Medicare, or that a dependent child loses dependent status, the Fund Office will give you and/or your covered dependents notice of the date on which your coverage ends and the information and forms they need to elect COBRA continuation coverage.

Under the law, you and/or your covered dependents will then have only **60 days** from the date you or they receive that notice, with information and forms to enable you and/or them to apply for COBRA continuation coverage.

**If you and/or any of your covered dependents do not choose COBRA continuation coverage within 60 days after receiving that notice, you and/or they will not have any group health coverage from this plan after coverage ends.**

COBRA continuation coverage may be elected for some members of the family and not others. In addition, one or more dependents may elect COBRA even if the employee does not elect it. However, in order to elect COBRA continuation coverage, the members of the family must have been covered by the Plan on the date of the Qualifying Event. A parent may elect or reject COBRA continuation coverage on behalf of dependent children living with him or her.

### **The COBRA Continuation Coverage That Will Be Provided**

If you choose COBRA continuation coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on the Cost of COBRA continuation

coverage for information about how much COBRA will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will be made in your COBRA continuation coverage.

**Cost of COBRA Coverage**

Individuals who continue full coverage under COBRA pay 102% of the Plan’s cost on an after-tax basis, except in cases of extended COBRA coverage due to disability. See the section entitled “COBRA Coverage in Cases of Social Security Disability” for details.

**Paying for COBRA Coverage**

The amount you, your covered spouse, and/or your covered dependent child(ren) must pay for COBRA coverage will be payable monthly. The Plan is permitted to charge the full cost of coverage for similarly situated active employees and families, plus an additional 2% - for a total charge of 102%.

The Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage, and of any monthly COBRA premium amount changes. The cost of COBRA continuation coverage may be subject to future increases during the period it remains in effect.

There will be an initial grace period of 45 days to pay the first amounts due starting with the date COBRA coverage was elected. If this payment is not made when due, COBRA continuation coverage will not take effect. After that, payments are due on the first day of each month. There will then be a grace period of 30 days to pay these monthly payments. **If payment of the amounts due is not made by the end of the applicable grace period, your COBRA coverage will automatically terminate.**

**COBRA AT A GLANCE**

<b>COBRA Coverage May Continue For:</b>	<b>If the Following Event Occurs AND Coverage is Lost:</b>	<b>Maximum Length of COBRA Coverage:</b>
You and Your Eligible Dependents	<ul style="list-style-type: none"> <li>• Your employment ends for any reason except gross misconduct.</li> <li>• Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund’s welfare benefits program.</li> </ul>	18 months (29 months if you or your eligible dependents is Social Security-disabled*.)
Your Eligible Dependents	<ul style="list-style-type: none"> <li>• You die.</li> <li>• You are divorced or legally separated.</li> <li>• You become entitled to Medicare.</li> <li>• Your child(ren) no longer qualifies as an eligible dependent under the Plan</li> </ul>	36 months

\*See “COBRA Coverage in Cases of Social Security Disability” for more information.

### **Duration of COBRA Coverage**

Your COBRA coverage can continue for up to 18, 29, or 36 months depending on the COBRA-qualifying event. The maximum duration of COBRA continuation coverage is measured from the date coverage is actually lost (rather than the date of the qualifying event, if different.)

#### **18 Months**

COBRA health coverage can continue for up to 18 months if you would otherwise lose Fund health coverage because of:

- **Your reduction in hours.**
- **Your change from active to inactive work status due to your:**
  - Resignation.**
  - Discharge (except for discharge for gross misconduct.)**
  - Disability.**
  - Strike.**
  - Layoff.**
  - Leave of absence (except for leave under the Family and Medical Leave Act (FMLA).)**
  - Retirement.**

#### **29 Months**

COBRA health coverage can continue for up to a total of 29 months if you or an eligible dependent becomes permanently disabled (as determined by the Social Security Administration), within the first 60 days of COBRA coverage, and you or your dependent notifies the Fund Office of the determination no later than 60 days after it was received and before the end of the initial 18-month COBRA period.

#### **36 Months**

COBRA health coverage for your dependents can continue for up to a total of 36 months from the date any one of the following COBRA-qualifying events occur:

- **Your death.**
- **Your divorce.**
- **You become entitled to Medicare.**
- **Your dependent is no longer eligible for Fund coverage.**

#### **COBRA Coverage in Cases of Social Security Disability**

If you, your spouse, or any of your covered dependent child(ren) are entitled to COBRA coverage for an 18-month period, that period can be extended for the covered person who is determined to be entitled to Social Security Disability Income benefits, and for any other covered family members, for up to 11 additional months (for a total of 29 months) if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA coverage, or within the first 60 days of COBRA coverage;
- The disabled covered person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration;
- The Plan must be notified by you or by the disabled covered person or another family member that the determination was received:
  - No later than 60 days after it was received; and
  - Before the 18-month COBRA continuation period ends.

This extended period of COBRA coverage will end at the **earlier** of:

- The last day of the month, 30 days after Social Security has determined that you and/or your dependent(s) are no longer disabled.
- The end of 29 months from the date of the COBRA qualifying event.
- The date the disabled individual becomes entitled to Medicare.

### **Cost of COBRA Coverage in Cases of Social Security Disability**

If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan will charge employees and their families 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month period following the 18<sup>th</sup> month of COBRA continuation coverage. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

### **Acquiring a New Dependent(s) while Covered by COBRA**

If you acquire a new dependent through marriage, birth, or placement for adoption while you are enrolled in COBRA continuation coverage, you may add that dependent to your coverage for the balance of your COBRA coverage period. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for five months of COBRA coverage. To enroll your new dependent for COBRA coverage, you must notify the Fund Office immediately after acquiring the new dependent. There may be a change in your COBRA premium amount in order to cover the new dependent.

If COBRA coverage ceases for you before the end of the maximum 18, 29, or 36 month COBRA coverage period, COBRA coverage also will end for our newly added spouse. However, COBRA coverage can continue for your newly added newborn child, adopted child or child placed with you for adoption until the end of the maximum COBRA coverage period if the required premiums are paid on time. Check with the Fund for more details on how long COBRA coverage can last.

### **Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage**

If, while you are enrolled in COBRA Continuation Coverage, your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible but not enrolled for coverage under the terms of the plan and, when enrollment was previously offered under the plan and declined, the spouse or

dependent must have been covered under another group health plan or had other health insurance coverage.

You must enroll the spouse or dependent **immediately** after the termination of the other coverage. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

**Medicare and second qualifying events.**

- (1) If you become entitled to COBRA Continuation Coverage because of termination of employment or reduction in hours that occurred less than 18 months after the date you become entitled to Medicare and
- (2) If your spouse and/or any dependent child has a second qualifying event as described in the first paragraph of this section, then your spouse and/or dependent child would be entitled to a 36-month period of COBRA Continuation Coverage beginning on the date you became entitled to Medicare. For example, your employment terminated on a date less than 18 months after you became entitled to Medicare, your spouse and/or dependent child who had a second qualifying event during the 18 months period of COBRA Continuation Coverage would be entitled to COBRA Continuation Coverage for a 36-month period beginning on the date you became entitled to Medicare.

**When COBRA Coverage Will Be Cut Short**

Once COBRA coverage has been elected, it will be cut short on the occurrence of any of the following events:

- The first day of the time period for which you don't pay the COBRA premiums within the required time period;
- The date on which the Fund is terminated;
- The date, after the date of the COBRA election, on which you or your eligible dependent(s) first become covered by another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a preexisting condition that the covered person may have;
- The date, after the date of the COBRA election, on which you or your eligible dependent(s) first become entitled to Medicare (usually age 65);
- If you fail to follow the Fund's policies and procedures and take actions that would result in termination of an active employee's coverage for cause. (For example, if you submit false claims to the Fund.)

**When COBRA Coverage Ends**

Your COBRA coverage ends on the earliest of the date that:

- Any of the above-listed events occurs.
- The COBRA period (18, 29, or 36 months) ends.

### **Confirmation of Coverage to Health Care Providers**

Under certain circumstances, federal rules require the Fund to inform your Health Care Providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule is applicable under the following two circumstances.

1. If a Health Care Provider requests confirmation of coverage during the COBRA election period, and you, your spouse or your dependent child(ren) have not yet elected COBRA continuation coverage, then the Fund Office will give a complete response to the Health Care Provider about you and your dependents' COBRA continuation rights during the election period.

The Fund cancels your and your dependents' coverage as of the date coverage ends under the Plan. However, the Fund retroactively reinstates your coverage once COBRA continuation coverage is elected. If you have not yet elected COBRA, the Fund Office will inform the Health Care Provider that you do not currently have coverage, but that you and your dependents' would have coverage retroactively to the date coverage was lost if you elect COBRA continuation coverage.

2. If, after you have elected COBRA continuation coverage, a Health Care Provider requests confirmation of coverage for a period for which the Fund Office has not yet received payment; then the Fund Office will give a complete response to the Health Care Provider about you and your dependents' COBRA continuation rights during that period.

The Fund cancels your and your dependents' coverage as of the first day of a period of coverage if it has not received your or your dependents' COBRA payment. However, the Fund retroactively reinstates your coverage once the COBRA payment is made. If you and/or your dependents have not paid the applicable COBRA payment, the Fund Office will inform the Health Care Provider that you do not currently have coverage, but that you and your dependents' would have coverage retroactively to the first day of the period of coverage if timely payment is made.

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## HEALTH CARE COVERAGE DURING A LEAVE OF ABSENCE

### **Family or Medical Leaves of Absence**

If your employer employed 50 or more employees in 20 or more work weeks in a current or preceding year and if you have worked for that employer for at least 1250 hours over the 12 months before you seek an unpaid leave for specified family or medical purposes (such as the birth or adoption of a child; to provide care for a spouse, child or parent who is ill; or for your own serious illness) you can continue your medical coverage during that leave period under the Family and Medical Leave Act of 1993 (FMLA). Your employer is required to contribute to the Fund for your health care coverage during the period of approved leave up to a maximum of 12 weeks. This obligation is applicable only to certain larger employers who have the requisite number of employees. If you do not return to work at the end of your FMLA leave, you may have to pay your employer back for any contributions your employer made to the Fund on your behalf during your leave. And, if you do not return to Covered Employment after your FMLA leave, you will not be entitled to COBRA coverage.

Questions regarding your entitlement to this leave should be referred to your employer.

### **Leave of Absence for Military Service**

If you are on active duty for 31 days or less, you will continue to receive health care coverage for up to 31 days, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on active duty for more than 31 days, you may be able to continue your medical and dental coverage at your own expense for up to 18 months. Please refer to the section entitled “*COBRA Continuation Coverage*” for a full explanation of the COBRA coverage provision, which will allow you to continue your medical and dental coverage. In addition, your dependent(s) will be eligible to coordinate most of their health care needs through the Civilian Health & Medical Program of the Uniformed Services (CHAMPUS).

If you have any questions about taking a leave, please speak directly with your employer. If you have any questions about how a leave or absence affects your benefits, please contact the Fund Office.

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## OTHER IMPORTANT INFORMATION

The Metal Lathers' Local 46 Welfare Trust Fund is administered by a joint Board of Trustees as listed below and at the front of this booklet.

The Board of Trustees is designated as the agent for service of legal process according to **ERISA** (Employee Retirement Income Security Act) regulations. The business address and telephone numbers of the Board of Trustees are:

Metal Lathers Local 46 Welfare Trust Fund  
260 East 78<sup>th</sup> Street  
New York, New York 10021

### **Union Trustees**

Robert A. Ledwith  
Terrence Moore  
Kenneth Allen  
Fred LeMoine, Jr.

### **Employer Trustees**

Alfred G. Gerosa  
Kevin O'Brien  
Rory DeJohn  
Dennis Ulversoy

### **Alternates**

James Langan  
Kevin Kelly

### **Funding of Plan**

Your employer makes contributions to the Welfare Trust Fund on a weekly basis to fund your benefits. Contributions are made according to the terms of the collective bargaining agreement. Income received by the Fund is held in a Trust Fund for the purpose of providing benefits to eligible members and for defraying reasonable administrative expenses. A copy of the collective bargaining agreement and a list of contributing employers are available upon written request to the Plan Administrator. Individuals may also make contributions in order to extend their coverage in the event that they are terminated from Fund coverage due to a qualifying event and they elect to continue coverage through COBRA.

### **Employer Identification Number (EIN)**

13-2878811.

### **Plan Year**

January 1 – December 31

### **Plan Number**

501

**Funding Medium**

The Fund's assets and reserves are held primarily in fixed income assets. The Fund's investment managers are Stacey Braun Associates, Amalgamated Bank, and GAMCO. The Bank of New York is the custodian of the Fund.

**Type of Plan**

Welfare benefits plan.

**Plan Amendments or Termination of Plan**

The Trustees reserves the right to amend or terminate this Plan, or any part of it at any time. Amendments may be made in writing by the Board of Trustees and become effective on the written approval of the Board of Trustees or on such other date as may be specified in the document amending the Plan. The Plan or any coverage under it may be terminated by the Board of Trustees and new coverages may be added as well.

**Discretionary Authority of the Plan Administrator and its Designees**

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan, including making any and all necessary factual determinations. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

**Type of Administration**

Hospital benefits, prescription benefits, comprehensive medical benefits, and vision benefits are insured by GHI, 441 Ninth Avenue, New York, NY 10001. Term life insurance, accidental death & dismemberment insurance, and accident & sickness insurance are insured through Prudential Insurance Companies of America, Five Penn Plaza, New York, NY 10001.

**Plan Contracts Govern**

Nothing in this Welfare Fund Booklet is meant to interpret or change in any way the provisions expressed in written agreements, the insurance policies or the master contracts. If there is a difference between this summary and such documents, then the terms of the written agreements, insurance policies, or master contracts will govern.

**Subrogation**

If you are injured because of the negligence or wrongdoing of another party, the Fund or the insurance carrier who has paid the claim has a right to seek recovery of benefits paid for the related expenses. If benefits have been paid under any provision of the Plan on account of services you received, and, after it is established that the charges for such services were not paid by you or your dependent or that you were otherwise reimbursed, the Fund will be entitled to a refund of the amount of benefits paid in excess of the benefits paid in excess of the benefits that would have been payable based on the actual charges incurred and paid by you or your dependent. You are expected to take any action necessary to protect and

support the subrogation rights of the Fund. This provision does not apply to any individual insurance policies covering you or your dependents.

### **No Liability for Practice of Medicine**

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

### **Discretionary Authority of Plan Administrator and Designees**

In carrying out their respective responsibilities under the Plan, the Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to administer, apply and interpret the Plan including this booklet, the Trust Agreement and any other Plan documents, to determine all matters arising in connection with the operation or administration of the Fund or the Trust and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

### **Privacy, Confidentiality, Release of Records or Information**

Any information collected by the Plan will be treated as confidential information and will not be disclosed to anyone without your written consent, except as follows:

- Information will be disclosed to those who require that information to administer the Plan or to process claims;
- Information with respect to duplicate coverages will be disclosed to the plan or insurer that provides duplicate coverage;
- Information needed to determine if health care services or supplies are medically necessary or if the charges for them are usual and customary will be disclosed to the individual or entity consulted to assist the Plan Administrator or its designee to make those determinations;
- Information will be disclosed as required by law or regulation or in response to a duly issued subpoena.

### **Information You or Your Dependents Must Furnish to the Plan**

In addition to information you must furnish in support of any claim for Plan benefits under this Plan, you or your covered dependents must furnish, within 60 days after the event, any information you or they may have that may affect eligibility for coverage under the Plan. This includes, but is not limited to:

- Change of name;
- Change of address;
- Marriage, divorce, or death of you or any covered spouse or dependent child.;

- Any information regarding the status of a dependent child including, but not limited to:
  1. The Dependent Child reaching the Plan's limiting age;
  2. The school status of a Dependent Child over age 18; or
  3. The existence of any physical or mental handicap.
- Medicare enrollment or disenrollment;
- The existence of other medical coverage.

Notices of the foregoing information should be sent, **in writing**, to the Fund Administrator at the following address:

Mr. Anthony D'Amico  
Metal Lathers Local 46 Welfare Trust Fund  
260 East 78<sup>th</sup> Street  
New York, New York 10021

**Agent for Service of Legal Process**

The Board of Trustees  
Metal Lathers Local 46 Welfare Trust Fund  
260 East 78<sup>th</sup> Street  
New York, New York 10021

Service may also be made on any individual member of the Board of Trustees

**Fund Administrator**

Mr. Anthony D'Amico  
Metal Lathers Local 46 Welfare Trust Fund  
260 East 78<sup>th</sup> Street  
New York, New York 10021

## **CLAIMS AND REVIEW PROCEDURE**

### **Filing of claims**

All claims for benefits must be submitted on claim forms made available by the Fund Office. You can access claim forms online as well. Simply click onto [www.metallatherslocal46.org](http://www.metallatherslocal46.org) and go to “your benefits” and then “forms”. For GHI claims submitted, they must be accompanied by any information or proof requested and reasonably required to process such claims.

### **Review Procedure if Your Claim Is Denied**

#### **Written Notice of Denial of Claim**

You will be notified in writing if payment of your claim is denied in whole or in part. The written notice will explain the reasons why with reference to the Plan provisions on which the denial was based.

#### **When Additional Information Is Needed**

When applicable, you will be told what additional information is required from you and why it is needed.

#### **Request for Review of Denial of Claim**

If your claim is denied or if you disagree with the amount paid on a claim, you may ask for a review. You may request a review or reconsideration by writing to the Fund Administrator within 60 days after you receive notice of denial. The review process works as follows:

- You have the right to review documents applicable to the denial and to submit your own comments in writing.
- Your claim will be reviewed by a person at a higher level of management than the one who originally denied the claim. If any additional information is needed to process your request for review, it will be processed promptly.
- The decision on any review of your claim will be given to you in writing. It will explain the reasons for the decisions, with reference to the applicable provisions of the Plan.

Ordinarily, a decision will be reached within 90 days after receipt of your request for review. However, in special circumstances, up to an additional 60 days may be necessary to reach a final decision. You will be advised in writing within the 90 days after receipt of your request for review if an additional period of time will be necessary to reach a final decision.

## RIGHTS OF PARTICIPANTS

As a participant in the welfare plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- *Examine*, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- *Obtain*, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- *Receive* a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.
- *Continue* health care coverage for yourself, spouse, or dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

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

If you have a claim for Plan benefits that is denied or ignored, in whole or in part, you have a right to file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Office of Pension and Welfare Benefits Administration (PWBA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington DC, 20210. You may also telephone a PWBA advisor in Washington, DC at (202) 219-8776 or visit the PWBA's Internet site at [www.dol.gov/dol/pwba](http://www.dol.gov/dol/pwba).