

**SUMMARY PLAN DESCRIPTION**

**Labor-Management Healthcare Fund  
Medical Plan**

**January 1, 2014**

## Plan Information

**Plan Name:** The Labor-Management Medical Plan

**Plan Sponsor/Plan Administrator Name, Address and Phone Number:** Board of Trustees  
Labor-Management Healthcare Fund  
3786 Broadway  
Cheektowaga, NY 14227  
(716) 601-7980

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

**Employer ID #:** 20-0422657

**Plan Year:** January 1 to December 31

**Agent for Service of Legal Process:** Board of Trustees  
Labor-Management Healthcare Fund  
(address and phone above)

**Plan Changes or Termination:** The Plan Administrator may terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Insurance Contract.

**Accompanying Documents:** **SPD** – This document, together with the appropriate Certificate of Coverage, constitutes your Summary Plan Description (“SPD”).

The term “Certificate of Coverage” refers to the plan documentation provided by BlueCross BlueShield of WNY (“BCBS”), which describes your hospital, medical, and durable medical equipment benefits in detail. Certificates of Coverage are sometimes also referred to as Certificates, Evidence of Coverage, Plan Booklets, etc. If you do not have a copy of your Certificate of Coverage, you may obtain one from the Plan Administrator.

The term “Insurance Contract” refers to the group insurance contract between BCBS and the Plan Administrator.

## Benefit Information

**Plan Name:** Labor-Management Medical Plan

**Type of Plan Benefit:**

- Active Employee:
  - Point of service health plan
  - Preferred provider organization health plan
  - Traditional Indemnity health plan
  - HDHP
  
- Pre-65 Retirees:
  - Point of service health plan
  - Preferred provider organization health plan
  - Traditional Indemnity health plan
  
- Post-65 Retirees:
  - Medicare + Choice HMO
  - Medicare + Choice preferred provider organization health plan
  - Traditional Indemnity health plan
  - Point of service health plan
  - Preferred provider organization health plan

**Contract Administrator:** Blue Cross Blue Shield of Western New York  
*Responsible for plan administration and payment of hospital and medical claims* 257 West Genesee Street  
Buffalo, NY 14202

*Hospital and medical benefits above are provided pursuant to an Insurance Contract between the Plan Sponsor and BCBS. If the terms of this summary document conflict with the terms of the Insurance Contract or with the Certificate of Coverage, the terms of the Insurance Contract will control, unless superseded by*

*applicable law. For further information about these Plan Benefits refer to the Certificate of Coverage or Insurance Contract for each separate benefit or contact the Plan Administrator.*

## **I Introduction**

This document is called a “Summary Plan Description”. Its purpose is to explain the provisions of your Employer’s insured group health plan, as provided through the Labor-Management Medical Fund (the “Fund”). You are urged to read this Summary Plan Description carefully and to acquaint your family with its provisions.

The Plan is comprised of insured benefits. Your hospital and medical benefits are provided through insurance coverage; your employer is not an insurer of those benefits. The sole source for those benefits is the insurance company.

Your prescription drug benefits are self-insured through the Fund under the Labor-Management Healthcare Fund Prescription Drug Plan. You should refer to the Summary Plan Description of that Plan for information concerning your prescription drug benefits.

This document does not replace the provisions of the group insurance policy. Every effort has been made to make this Summary Plan Description as complete and accurate as possible. In the event of any difference between the Summary Plan Description and the insurance policy, the terms of the policy will control.

If you have any questions about your benefits under the Plan, please contact your Employer.

## **II Funding Medium and Type of Plan Administration**

The Plan is maintained pursuant to a collective bargaining agreement between your Employer and your Union. Your Employer contributes to the Fund on your behalf. If you are required to contribute toward the cost of coverage, this will be done through your individual Employer as well.

Hospital and medical benefits under the Plan are fully insured. Benefits are provided under a group insurance contract entered into between Blue Cross Blue Shield of Western New York (“BCBS”) and the Fund, which will own the group contract providing benefits to all eligible participants. Claims for benefits are sent to BCBS. BCBS (not your Employer or the Fund) is responsible for paying these claims.

### III Insurer Information

If you need specific information regarding the extent of your medical and hospitalization coverage under this Plan, the benefits offered through your insurance, or how to make a claim for benefits, you should contact BCBS at the following address and telephone numbers:

#### BlueCross BlueShield of Western New York

Customer Service:  
Local (716) 887-8840  
Toll Free 1-877-576-6440  
TDD Line (716) 886-7863

Claims Mailing Address:  
BlueCross & BlueShield of W.N.Y.  
P.O. Box 80  
Buffalo, NY 14240-0080

Mental Health and Substance Abuse  
Toll Free 1-877-837-0814

A clinician will assist you with determining the most appropriate type of provider for the services you need and will arrange treatment.

Health Advocate  
Toll Free 1-800-359-5465

A 24-hour service to help members navigate through the healthcare system. Health Advocate is a resource to provide medical/clinical information. They will assist you in preparing for physician visits and help you to understand chronic conditions. They also provide assistance with complex claims and billing issues.

Reminder: If you are outside of the service area and you experience an unexpected illness or injury that is not life threatening, you can call your primary care physician or Health Advocate for guidance. If treatment is advised, call 1-800-810-2583 to locate an in-network provider for an appointment.

You can also find out other important information regarding the types of benefits offered by your Insurer at [www.bcbswny.com](http://www.bcbswny.com).

### IV Group Insurance Plan

Your Employer provides hospital, medical, and durable medical equipment group insurance benefits to eligible employees through the Fund. The insurance carrier will provide you with a booklet or certificate describing the insurance benefits provided by that carrier.

The booklet or certificate will contain the following information:

- The eligibility conditions for any dependent coverage

- A summary of benefits
- A description of any deductibles, coinsurance or co-payment amounts
- A description of any annual or lifetime caps or other limits on benefits
- Whether and under what circumstances preventive services are covered
- Whether and under what circumstances prescription drugs are covered
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures
- Provisions governing the use of network providers (if any). If there is a network, the booklet or certificate will contain a general description of the provider network and you will be entitled to obtain a list of providers in the network from the Insurer
- Whether and under what circumstances coverage is provided for out-of-network services
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care
- Any conditions or limits applicable to obtaining emergency medical care
- Any provisions requiring pre-authorization or utilization as a condition to obtaining a benefit service
- A summary of claims procedures

## **V Eligibility and Participation**

Eligibility for participation in the Plan is determined according to rules adopted by your individual Employer in accordance with your collective bargaining agreement. You should contact your Employer to see if you are in a job classification eligible for coverage under this Plan. Your BCBS insurance booklet sets forth the eligibility rules for your spouse and children.

## **VI Enrollment**

You must complete an application form (available through your Employer) to enroll yourself and/or your eligible spouse and dependents. New employees must enroll within certain time periods after being hired, as discussed in the BCBS insurance booklet. Otherwise, enrollment generally is limited to the annual open enrollment period that occurs before January 1 of each year.

In certain circumstances, enrollment may occur outside the open enrollment period. The BCBS insurance booklet and “Special Enrollment Notice” contain information about special enrollment rights.

## **VII Coordination of Benefits**

The coordination of benefits sets out rules for the order of payment of medical benefits when two or more plans—including Medicare—are paying. If you are covered by this Plan and another plan, or your spouse is covered by this Plan and by another plan, or your dependent children are covered by two or more plans, the plans will coordinate benefits when a claim is received. The rules for determining which plan pays first are set forth in the BCBS insurance booklet.

## **VIII Certificates of Credible Coverage**

BCBS will be responsible for issuing certificates of credible coverage to eligible participants. This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. The certificate is a written document that reflects certain details about your prior health coverage, including the dates you were covered, and may be necessary to reduce the extent to which a group health plan or an issuer offering health insurance coverage in the group market can apply a preexisting condition exclusion. If you become covered under another group health plan, contact the Fund to obtain your certificate of creditable coverage.

## **IX Mental Health Parity & Addiction Equity Act**

The Mental Health Parity Act of 1996 (MHPA) is a law that prevents your group health plan from placing annual or lifetime limits on mental health benefits that are lower, or less favorable, than annual or lifetime limits for medical and surgical benefits offered under the Plan. The term “mental health benefits” means benefits for mental health services defined by the health plan or coverage.

The Mental Health Parity & Addiction Equity Act of 2008 (MHPAEA) preserves the MHPA protections, and adds significant new protections.

Key changes made by MHPAEA, include the following:

- The financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health benefits and substance use disorder benefits (MH/SUD) must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;
- MH/SUD benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits;
- If your group health plan provides for out of network medical/surgical benefits, it must provide for out of network mental health and substance abuse disorder benefits;

- Standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD must be disclosed upon request.

Although these laws require parity with regard to financial and treatment limits, neither law requires group health plans and their health insurance issuers to include mental health coverage in their benefits package. The laws' requirements apply only to group health plans and their health insurance issuers that include mental health benefits in their benefits packages. Therefore you should contact BCBS for more information as to what extent, if any, mental health benefits are offered.

## **X Qualified Medical Child Support Orders**

Notwithstanding any contrary provision in any group health insurance policy under the Plan, an eligible dependent child may include a child for whom an employee is required to provide coverage pursuant to a qualified medical child support order.

## **XI Your Rights Under the Newborn's and Mother's Health Protection Act**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or the newborn's attending provider, after counseling with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## **XII Sources of Contribution and Cost of Benefits**

Your Employer will pay the applicable insurance premiums to the Fund on behalf of the employees who participate in the Plan. Employees and retirees may be required to contribute to the cost of coverage. If you are required to contribute to the cost of coverage, your Employer will notify you of the required premiums.

## **XIII Continuation Coverage/New York's Age 29 Law**

COBRA continuation coverage allows you and your dependents an opportunity to temporarily extend your health insurance coverage under the Plan at group rates in certain instances where coverage would otherwise end. New York State continuation coverage, known as "mini-



COBRA,” provides rights similar to federal COBRA to a member of a group covered by a health insurance contract issued in New York.

**Eligibility.** You or your dependents that are eligible to purchase continuation coverage are “qualified beneficiaries”. If a child is born to or adopted by or placed for adoption with an employee during a period of COBRA continuation coverage, the newborn or newly adopted child’s maximum continuation period shall be measured from the date of the initial qualifying event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle you or your dependents (as qualified beneficiaries) to continuation coverage are “qualifying events”. The qualifying events, the qualifying beneficiaries, and the maximum continuation period are described in the following chart:

Qualifying Event	Qualified Beneficiary	Continuation Period (Months)
Reduced hours* or termination of employment **	Employee and Dependents	18 or 36 for insured plans***
Employee’s death	Dependents	36
Employee’s entitlement to Medicare	Dependent not entitled to Medicare	36
Dependent child becomes ineligible for coverage	Ineligible Dependent	36
Employee’s divorce/legal separation	Dependents	36

\* A reduction in hours due to family or medical leave, as defined by the Family and Medical Leave Act of 1993 (“FMLA”), shall not cause an employee’s participation to terminate, to the extent required by FMLA. Thus, a reduction in hours pursuant to an FMLA leave shall not constitute a qualifying event. However, if the employee does not return to work at the end of the FMLA leave, a qualifying event shall occur as of the last day of the FMLA leave.

\*\* Continuation coverage is not available if employment is terminated for gross misconduct.

\*\*\*Although self-insured benefits, such as the Plan’s pharmacy coverage, are not subject to New York’s 36 month continuation period, the Plan will permit 36 months of continuation coverage for this benefit.

**Notice Requirements.** A qualified beneficiary must inform your Employer of a divorce or legal separation, or of a child losing dependent status under the plan, within sixty (60) days after the later of: the date of the qualifying event or the date the qualified beneficiary loses health coverage on account of that qualifying event. If timely notice is received, the Employer has the responsibility to notify BCBS of the divorce, legal separation or loss of dependent status. Your employer also has the responsibility to notify BCBS of your death, termination of employment, reduction in hours, or Medicare entitlement.

Your employer will notify all eligible qualified beneficiaries of their right to elect continuation coverage. If a qualified beneficiary chooses to purchase continuation coverage, the qualified beneficiary must notify your employer in writing within sixty (60) days after the later of: the date the qualified beneficiary loses health coverage on account of the qualifying event or the date on which the qualified beneficiary is sent notice of his or her eligibility for continuation

coverage. If the qualified beneficiary does not choose continuation coverage during the sixty (60) day period, his or her participation will end as otherwise provided in the Plan Booklet.

**Coverage.** If a qualifying event occurs, you and your dependents who are qualified beneficiaries must be offered the opportunity to elect to receive the group health coverage that is provided to similarly-situated nonqualified beneficiaries. Generally, this means that if you or your dependents purchase continuation coverage, it will be the same as the health coverage provided to you immediately before the qualifying event. Each qualified beneficiary has the right to make an independent election to receive continuation coverage.

Qualified beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated participants, the same modifications will apply to you and your dependents. Qualified beneficiaries who purchase continuation coverage will have the opportunity to elect different types of coverage during an annual open enrollment period in accordance with the opportunity to provide similarly-situated active employees.

**Cost.** Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost may be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries who elect an additional eleven (11) months of continuation coverage, the cost may be 150% of the cost of identical coverage for similarly-situated participants for the additional eleven (11) month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law). The 150% cost amount shall also apply to the disabled qualified beneficiary's dependents, as long as the disabled qualified beneficiary is in the coverage group receiving COBRA.

The initial premium must be paid within forty-five (45) days after the qualified beneficiary elects continuation coverage. Subsequent premium must be paid monthly, as of the first day of the month, with a thirty (30) day grace period for timely payment. However, no subsequent premium will be due within forty-five (45) days after the qualified beneficiary elects continuation coverage. Payment is considered made on the date on which it is sent to the plan.

**Termination.** Generally, continuation coverage terminates at the end of the 36-month continuation period. However, continuation coverage for a qualified beneficiary may end before the end of the continuation period for any of the following reasons:

- **Coverage Terminated**  
Employer no longer offers a group health plan to any of its employees;
- **Unpaid Premium**  
The premium for continuation coverage is not timely paid;
- **Other Coverage**  
The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan. However, this provision does not apply during any time period the other group health plan contains any limitation or exclusion with regard to any pre-existing conditions, other than a limitation or

exclusion which does not apply to the qualified beneficiary or is satisfied by the qualified beneficiary due to the Health Insurance Portability and Accountability Act;

- **Medicare**

The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B); or

- **Cause**

The date on which a qualified beneficiary's coverage is terminated for cause on the same basis that the plan terminates for cause the coverage of similarly-situated nonqualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits).

**New York's Age 29 Law.** Your children may have the right to elect coverage under New York's Age 29 Law in lieu of COBRA or state continuation coverage. BCBS will notify you of this right. The Plan will permit your child to continue pharmacy coverage for as long as your child is entitled to BCBS coverage under New York law.

#### **XIV Claims Procedure – Rescission of Coverage**

A Rescission of Coverage is a cancellation or discontinuance of medical coverage that is effective **retroactively** and that is not due to a failure to timely pay required contributions toward the cost of coverage. You do not need to file a claim regarding a Rescission of Coverage. If you are notified by your employer or the Plan Administrator or their delegate that your coverage under the Plan is being rescinded, that notification is considered to be a claim denial. You may appeal a Rescission of Coverage within 180 days after your receipt of the notice of Rescission of Coverage. Your appeal will be considered within 60 days after the Plan Administrator receives your appeal, with a 60-day extension permitted if necessary.

Please submit your appeal to the following address:

Labor-Management Healthcare Fund  
Attn: Vicki Martino, Executive Director  
3786 Broadway  
Cheektowaga, NY 14227  
(716) 601-7980

#### **XV Claims Procedure – Hospital and Medical Claims**

BCBS is responsible for evaluating all hospital and medical benefit claims under the Plan, and will decide your claim in accordance with its own claims procedures. BCBS has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If BCBS denies your claim, in whole or in part, you will receive a written notification setting forth the reasons for the denial. See the Plan Booklet issued by BCBS for more information about how to file a claim and for details regarding their claims procedures.

If your claim is denied, you may appeal to BCBS for a review of the denied claim. They will decide your appeal in accordance with their own appeal procedures. See the Plan Booklet issued by BCBS for more information about how to appeal a denied claim and for details regarding their claims procedures.

## **XVI COMPLIANCE WITH HIPAA PRIVACY STANDARDS.**

Certain members of the Fund's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these Employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these Employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the following provisions apply:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Fund's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Fund's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.
- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Fund's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Fund's workforce" shall refer to all Employees and other persons under the control of the Plan Administrator.
  - (a) **Updates Required.** The Plan Administrator shall amend this document promptly

with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

- (b) **Use and Disclosure Restricted.** An authorized member of the Fund's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
- (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Fund's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
  - (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
  - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach may include, oral or written reprimand additional training, or termination of employment;
  - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
  - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) **Certification of Plan Administrator.** The Plan Administrator must provide certification to the Plan that it agrees to:
  - (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
  - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Fund with respect to such information;
  - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Fund;
  - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;
  - (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

- (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Fund still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- (j) Ensure the adequate separation between the Plan and member of each Employer's workforce, as required by Section 164.504(f) (2) (iii) of the Privacy Standards.

## **HIPAA NOTIFICATION**

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires, among other things, that health plans protect the confidentiality and privacy of individually identifiable health information. A description of a Covered Person's HIPAA Privacy rights are found in the Privacy Notice, which has been distributed to each Employee covered under the health plan.

The Plan and those administering it will use and disclose health information only as allowed by federal law. If a Covered Person has a complaint, questions, concerns or requires a copy of the Privacy Notice, please contact the Privacy Official in the Plan Administrator's office.

## **XVII Amendment and Termination**

The Trustees have established this Plan with the intent that it will be maintained for an indefinite period of time. However, the funding for the Plan is conditioned on a collective bargaining agreement remaining in effect that provides for continued Employer contributions to the Fund. Therefore, the Trustees reserve the right to amend or terminate the Plan, in whole or in part, at any time.