

BRICKLAYERS INSURANCE & WELFARE FUND
SUMMARY PLAN DESCRIPTION
FOR
ACTIVE PARTICIPANTS

(Amended and Restated January 1, 2019)

NAMES AND ADDRESSES OF
THE BOARD OF TRUSTEES

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To All Participants – A Message from the Board of Trustees (“Board or Trustees”)

We are pleased to present you with this new Summary Plan Description (“SPD”) for the Bricklayers Insurance and Welfare Fund (the “Plan”). This SPD constitutes the Plan’s official plan document and summary plan description, and is effective as of April 1, 2017. Accordingly, this SPD applies to plan benefits rendered or received on or after such date. For services rendered prior to that date, please refer to the Plan’s prior Summary Plan Description (as amended), notices and documents for the applicable period.

This SPD describes the comprehensive benefits currently available active participants and their eligible dependents who qualify for coverage under the Plan effective as of April 1, 2017. The SPD also provides information about how you qualify for benefits, covered services, how to file a claim and your rights under the Plan. To obtain additional information about the operation of the Plan, contact the Administrator at the following address and phone number:

Address: Bricklayers’ Insurance and Welfare Fund
66-05 Woodhaven Boulevard
Rego Park, New York 11374
Phone: (718) 459-5800

Local Union referred to in this booklet is the Bricklayers and Allied Craftworkers Local Union #1, NY, 4 Court Square, Long Island City, New York 11101 (the “Union”). In addition, please note that there is also a separate, stand-alone Retiree Plan for retired participants who meet the eligibility rules as described below. The welfare benefits for retirees are described in the Bricklayers Insurance & Welfare Fund Retiree Plan’s Summary Plan Description. When you retire from active coverage and if you meet the eligibility rules, you will be notified of your eligibility and sent a Summary Plan Description and an enrollment card in order to enroll in the Retiree Plan.

Employer and Union representatives and individual Trustees are not authorized to interpret the Plan, its benefit provisions or its eligibility requirements. The Trustees have sole and exclusive authority to interpret the Plan and to make final determinations regarding its provisions. The Trustees’ decisions are final and binding. Only the full Board can make such interpretations. If you would like a specific benefit provision clarified, you should contact by writing to the Administrator at the address shown above.

The Trustees intend to continue the benefit programs described in this SPD. Nevertheless, it reserves the right, subject to the terms of a collective bargaining agreement, to terminate or amend any or all of the Plan’s benefit programs, including benefits for retirees, in whole or in part at any time in the future. If the Plan is amended or terminated, the ability of any person to participate and receive benefits from the Plan may be modified or terminated.

Every effort has been made to ensure that this SPD is easy to understand. We hope you will read this material carefully, discuss it with your family, and then keep it for future reference. If you have specific questions about your health benefits, contact the Fund Office at (718) 459-5800.

Sincerely,

The Board of Trustees

Notificación de asistencia con traducciones al español

Este documento es un resumen del plan, el cual contiene un resumen en inglés de sus derechos y beneficios según el plan de salud de Bricklayers Insurance and Welfare Fund for Active Participants (“Fund”). Si tiene dificultades para entender cualquier parte de este documento, comuníquese con un representante de Fund al (718) 459-5800, de 9:00 a.m. a 4:00 p.m. Hora estándar del Este, o visite una de las oficinas de Fund:

Bricklayers’ Insurance and Welfare Fund
66-05 Woodhaven Boulevard
Rego Park, New York 11374
Phone: (718) 459-5800

Keep the Plan Informed About Life Changes.

Make sure your Plan benefits change with you. It’s important that you update the Fund Office and the Health Center about changes in your life and business affairs — to keep your benefits current and to ensure that you and your dependents receive all the benefits to which you are entitled.

Generally speaking, you have 30 days to notify the Fund Office when a life event that affects your coverage occurs, but be sure to check the specific provisions in this SPD that apply to your situation. You need to understand the time frame within which you must provide notification to Fund Office, and what documentation may be required. To learn what you must do to update and protect your benefits when your life changes, please refer the various life events referenced throughout this SPD.

In addition, you should make sure that the Fund Office always has your current mailing address. This is critically important, as the Fund Office frequently sends you important information about your benefits under the Plan. Also, remember that Fund Office is a separate legal entity from the Union. This means that even if you’ve already notified the Union of an update of any information or situation (like a change of address), you must also notify the Fund Office. Notifications, along with any required documentation, of any life events which may affect your coverage must be sent directly to the Fund Office.

Use the Plan’s Current Forms

The most current versions of all required forms mentioned in this SPD may be requested by calling the Fund Office at (718) 459-5800. Always check with the Fund Office to confirm that you are using the most up-to-date versions of required forms.

GRANDFATHERED HEALTH PLAN UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (THE AFFORDABLE CARE ACT or PPACA)

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the Bricklayers’ Insurance and Welfare Fund, 66-05 Woodhaven Boulevard, Rego Park, NY 11374 or via phone at Phone: (718) 459-5800.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or <http://www.dol.gov/ebsa/healthreform/>. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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ELIGIBILITY

BENEFIT ACCRUAL AND BENEFIT PROGRAM PERIODS

For the purposes of determining eligibility for benefits, hours paid means the number of hours you work in Covered Employment in the jurisdiction of the BAC Local Union #1, NY, for which contributions are made to this Plan on your behalf by Contributing Employers or for which you can establish, in accordance with Fund Office procedures, that contributions are owed to this Plan by an Employer that is obligated to contribute to this Plan. The Fund Office reviews contribution received on a periodic basis in order to determine if you meet the initial or ongoing eligibility requirements as follows.

All regular full time employees of the Unions, and all regular full time employees of their affiliated fringe benefit funds, first become eligible for benefits provided by this Plan the first of the month following the start of employment.

Initial Eligibility

You are initially eligible for coverage under this Plan for Benefit Program B once you work 750 hours in covered employment in any Benefit Accrual Period. Once you meet the hours requirement, coverage will begin the first of the following month in which you work 750 and lasts until the end of the Benefits Accrual Period in which you first become eligible.

Ongoing Eligibility

Once you met the initial eligibility requirement, the number of hours you work during a Benefit Accrual Period determines the level of benefits (e.g., the Benefits Program), for which you and your eligible dependents will be eligible as described below. The Benefit Accrual Period is the period for which you are eligible for benefits.

The Benefit Accrual Period is the full calendar year that runs from January 1st to December 31st. The Benefit Program period runs from April 1st to March 31st of the next year. For example, your benefit eligibility for the 2017 program period beginning April 1st is based on your hours of work during the 2016 Benefit Accrual Period (2016 calendar year).

There are two (2) levels of Benefit Programs for participants and their eligible dependents. The Benefit Program you are eligible for is determined based on the number of hours you work for Contributing Employers in a Benefit Accrual Period.

Benefit Program eligibility is as follows:

<i>If You Work This Number of Hours in a Benefit Accrual Period (January 1st to December 31st)</i>	<i>You Will be Eligibility for benefits for the following Benefit Program During the Benefit Program Period (April 1st to March 31st):</i>
1,200 or more	A
750 – 1,199	B

Less than 750 hours	None
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Beginning with the April 1, 2017 through March 31, 2018 Benefit Program Period, if you work at least 600 hours in covered employment in a calendar year (also known as the Plan Year) but, due to an on the job injury, you fail to work the required 750 hours during that calendar year necessary for Plan B coverage in the subsequent Benefit Program Period, you **may** be eligible to purchase the additional hours necessary to obtain Plan B coverage, **up to a maximum** of 150 hours.

Eligibility for this provision is contingent on the following:

- You were injured on the job and received, or are receiving, Workers Compensation for your injuries during the calendar year.
- You qualified for either Plan A or Plan B coverage under the Plan in the two Benefit Program Periods **immediately** prior to the upcoming Benefit Program Period.
- You must elect to purchase, and pay for, the required hours by May 31, 2017 for the April 1, 2017 through March 31, 2018 Benefit Program Period only up to a maximum of 150 hours for Plan B coverage.
- In future years, if you are injured and receiving workers compensation for your injury, you must elect to purchase, and pay for, the required hours prior to the beginning of the upcoming Benefit Program Period (meaning by April 1st) up to a maximum of 150 hours for Plan B coverage.
- The cost of each hour to be purchased will be based on the highest hourly contribution rate of the Plan in effect during the period of time you were receiving Workers Compensation.

DEPENDENT ELIGIBILITY

Eligible Dependents

For the purposes of this Plan, the following are the persons who will be eligible for dependent coverage:

1. Your lawful spouse (same-sex or opposite sex) to whom you are legally married in accordance with applicable federal and state law;
2. Each of your dependent children under the age of 26, regardless of their marital status, place of residence, student status, access to other health insurance coverage, or financial dependency; provided that the necessary supporting documents are forwarded to the Fund Office. The term “children” will include legally adopted children, children placed for adoption, stepchildren, and grandchildren of whom the participant is legal guardian. Coverage will terminate for a dependent child on the first day of the month following the child’s 26th birthday. Except as otherwise provided under the Plan, if an enrolled child is married, coverage, however, will not be extended to the child’s spouse or children.

3. Unmarried mentally and physically handicapped children over the age of 26 who become incapacitated before reaching age 26 and are incapable of self-sustaining employment who are dependent on you and/or your spouse for support and maintenance.

If you are unmarried and have no dependent children and are eligible for benefits as described in this summary, your mother and father will be considered to be dependents, provided you furnish more than half of their support. In order to claim your parents as dependents, you will be required to furnish proof that they were your dependents according to Federal Income Tax Laws during the calendar year preceding the date you wish to enroll them. You should consult with your tax advisor for advice on the tax consequences of enrollment.

A Word About Same-Sex Marriages in light of the U.S. Supreme Court’s decision on the constitutionality of the federal Defense of Marriage Act (“DOMA”).

Generally speaking, on June 26, 2013 the U.S. Supreme Court held that a portion of DOMA is unconstitutional. The part of DOMA that was found to be unconstitutional limited “marriage”, for all federal law purposes, to a legal union between one man and one woman and limited “spouse” to a person of the opposite sex who is a husband or wife. The Supreme Court generally concluded that states have the right to determine issues relating to family matters, including the definition of marriage, and that the federal law should look to those state determinations. Since the Supreme Court’s decision, federal regulators have ruled that all same-sex couples legally married in jurisdictions that recognize same-sex marriages will be treated as married for federal tax purposes, regardless of whether the couple lives in a state or other jurisdiction that recognizes same-sex marriage.

This means that if you are legally married in a state or other jurisdiction that permits same-sex marriage, your same-sex spouse will be considered your spouse for all purposes under the Plan regardless of the marriage laws of the state or other jurisdiction in which you currently live. For example, in that case:

- Your spouse will be considered a spouse for purposes of dependent eligibility, COBRA eligibility and HIPAA special enrollment rights.
- Your spouse’s children will be recognized by the Plan as Step-Children and they are eligible to be added to the plan as your covered dependents.

In addition, in that case, the value of your same-sex spouse’s coverage under the Plan would no longer be taxable income to you for federal tax purposes. Thus, the Plan would not have to collect taxes in the event that you are required to pay premiums for dependent coverage.

You should note that similar rights are not available to same-sex domestic partners who are not “spouses” under state law. So, for instance, couples in domestic partnerships, civil unions or other relationships that are not “marriages” under state law are not considered to be married for federal tax purposes. As a reminder, the Plan does not provide coverage for domestic partners.

Enrollment

When you initially become eligible for benefits, the Fund Office will send you an enrollment form. You must complete and sign the enrollment form and return it to the Fund Office in order for coverage to become effective. If there is any question as to your eligibility or you think that you should be eligible for benefits but have not received an enrollment form or you think you have worked hours that have not been reported, you should contact the Fund Office as soon as possible. For your dependents to be eligible, you need to enroll them and provide proof of dependent status. You can also obtain an enrollment card from the Fund Office.

A Dependent may not be enrolled for coverage unless the employee is also eligible and enrolled. Specific documentation listed below to substantiate Dependent status is required by the Plan.

Note that failure to provide timely proof of dependent status means that claims submitted to the Plan for the dependents will not be able to be considered for payment until such proof is provided. Also, if an enrolled dependent no longer qualifies for coverage and you do not notify the Fund Office, you will be required to reimburse the Plan for any benefits paid incorrectly by the Plan and such dependent coverage will be terminated.

For each dependent, you will need to provide a copy of their social security card and a copy of the following document(s), as applicable:

- **Spouse/Marriage:** the certified marriage certificate.
- **Child/Birth:** the certified birth certificate showing biological child of employee
- **Stepchild:** the certified birth certificate, divorce decree between the child's natural parents (if applicable) and marriage certificate between employee and child's natural or adoptive parent.
- **Adoption or placement for adoption:** court order paper signed by the judge showing that employee has adopted or intends to adopt the child and certified birth certificate.
- **Foster Child:** court order documents signed by a judge verifying legal custody of the foster child (e.g. placement papers from a qualified state placement agency), or proof of judgment, decree or court order from a court of competent jurisdiction, plus the child's birth certificate and proof of any state-provided health coverage.
- **Grandchild for Whom the Participant has Legal Guardianship:** the court-appointed legal guardianship documents and certified birth certificate as well as tax documents.
- **Disabled Dependent Child:** Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically disabled and that disability existed before the attainment of the Plan's age limit and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly on you and/or your spouse for support and maintenance. The plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of dependent child including proof that the child is claimed as a dependent for federal income tax purposes.
- **Qualified Medical Child Support Order (QMCSO):** Your divorce settlement may name who will provide health care benefits for your children. Alternatively, you may be required to

provide coverage for your children under federal law. A Qualified Medical Child Support Order (“QMCSO”) may require the Plan, under certain circumstances, to provide coverage for your children when you and your spouse divorce.

The Plan will comply with a QMCSO issued by a judge, or a National Medical Support Order (NMSO) issued by a state agency which meets the requirements of a QMCSO. These types of orders require the Plan to provide medical coverage for the child of a member who does not have custody of that child. If a QMCSO or a NMSO is received, the Fund Office or your employer will provide written notification to you and each child of his or her eligibility for coverage and will permit immediate enrollment. This notice will include any required enrollment material, a description of the procedures to be followed and a form for designating the child’s custodial parent or legal guardian as his or her representative for all purposes. Contact the Fund Office for more information. Accordingly, a valid QMCSO document signed by a judge or a National Medical Support Notice.

If you divorce, a QMCSO could have an effect on your benefit coverage or elections. Accordingly, please notify the Fund Office if you become aware of this type of order as part of a divorce proceeding.

Special Enrollment

If you did not initially enroll your spouse or dependent children because they had other coverage and they cease to be eligible for that other coverage, you may enroll them in the Plan at the time they lose other coverage. In addition, if you acquire a dependent by marriage, birth, adoption or placement for adoption, you may enroll your new dependent effective as of the date of the marriage, birth adoption or placement for adoption by completing an enrollment card. You must provide the necessary proof (as listed above) in order to enroll your dependent.

You and your dependents may also enroll in this Plan if you (or your eligible dependents):

- have coverage through Medicaid or a State Children’s Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage.
- become eligible for a premium assistance program through Medicaid or CHIP.

To request enrollment, please contact the Fund Office.

Effective Date of Coverage Following Enrollment

If you return your completed enrollment form and all the necessary proof to the Fund Office within 31 days of the event, coverage will be effective retroactive to the date you were first eligible or the date you add the new dependent (or from the date of the loss of other coverage). You may enroll after 31 days. However, if you do, coverage will not be effective until the month after the month in which the Fund Office receives your completed enrollment material. Keep in mind that no claims for your or your covered dependents will be payable until the Fund Office receives your completed Enrollment form as well as the required proof of dependent status.

BENEFITS FOR DEPENDENTS OF DECEASED PARTICIPANTS

The dependents of a participant who was eligible for benefits at the date of his death will continue to be covered for the same level of benefits for a period of 12 months following the month in which death of the participant occurred at no cost, if the participant was covered under Benefit Program A or B. Thereafter, dependents may avail themselves of COBRA Option privilege, see page 11.

DISABILITY CONTINUATION

A participant who is eligible for benefits and becomes disabled or hurt on the job will continue to be eligible for benefits for as long as he or she remains unable to work because of the disabling condition, for up to one year. If you do not return to covered employment following any such period of extended coverage, you and your eligible dependents are eligible for COBRA at the conclusion of the period.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan does not otherwise provide, except as required by a state's Medicaid-related child support laws. 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.

If a court or state administrative agency has issued an order with respect to health care coverage for any dependent child of the employee, 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. The Plan Administrator or designee will notify the parents and each child if an order is determined to be a QMCSO, and if the employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).

Enrollment Related to a Valid QMCSO: If the Plan has determined that an order is a valid QMCSO it will accept enrollment of the alternate recipient as of the earliest possible date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions.

The QMCSO may require the Plan to provide coverage for the employee's Dependent Child(ren). The Plan will accept a Special Enrollment of the alternate recipient specified by the QMCSO from either the employee or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified on the QMCSO or if not specified, the first day of the month after the Special Enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, including any requirements for authorization of services, as permitted by applicable law.

Termination of Coverage: Generally, coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other Dependent children (including the child reaching the limiting age or termination of the participant's coverage). When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage. See also the COBRA section of this document.

Additional Information: For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact the Fund Office.

FAMILY MEDICAL LEAVE ACT

The Family Medical Leave Act, 29 USC §2601 et seq. provides that if you work for an employer covered by that Act you are entitled to 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 seriously ill, or for your own illness. You may also be entitled to unpaid leave to take care of a military service member who is your spouse, child, parent, or next-of-kin and is undergoing medical treatment or recuperating from serious illness or injuries as a result of their service. In general, the employers covered by FMLA are those who employ 50 or more employees for each working day during each of twenty or more calendar weeks in the current or preceding calendar year. If you are taking FMLA leave that has been approved by your employer, your employer is responsible for making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility. To find out more about Family or Medical Leave (or other paid leave rights under applicable state law) and the terms on which you may be entitled to it, contact your Employer.

Expanded FMLA Rules for Military Personnel

The 2010 National Defense Authorization Act ("NDAA") amends the Family and Medical Leave Act of 1993 by expanding its leave provisions relating to "qualifying exigency leave" and "military caregiver leave." FMLA leave is available to covered employees whose spouse, child or parent is in the U.S. Armed Forces, including the National Guard or Reserves, who is ordered to active duty and who is deployed overseas. "Qualifying exigencies" include time preparing for short notice deployment, arranging for child care, updating financial or legal arrangements, attending counseling, time for rest and recuperation and post-deployment activities. You may be entitled to up to 12 weeks of leave within a 12-month period for a "qualified exigency."

The 2010 NDAA also amends the FMLA to create leave protections for family members of injured veterans who provide “military caregiver leave.” They may be entitled to a total of 26 weeks of unpaid leave during a 12-month period to care for the service member. This form of leave applies only if the service member in need of care is under-going medical treatment, recuperation or therapy (including outpatient care) for a serious illness or injury that was incurred in the line of active duty and that may render the service member medically unfit to perform the duties of his or her office, grade, rank or rating. Note: If you take this type of leave along with a FMLA leave for any other purpose (for example, the birth of a child), the combined total leave may not exceed 26 weeks in the 12-month period.

If you believe that you qualify for FMLA leave, please contact your employer and advise the Fund Office.

MILITARY LEAVE UNDER USERRA

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee’s coverage under this Plan will terminate when the employee enters active duty in the uniformed services. However, if the employee goes into active military service for up to 31 days, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period.

Duty to Notify the Plan: The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the employee in writing that they have been called to active duty in the uniformed services and provides a copy of the orders. The employee must notify the Fund Office as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working.

USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage are the same and will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. (See the COBRA section for more details). However, keep in mind that USERRA is an alternative to COBRA. Therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of

the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

USERRA allows employees to use their accumulated eligibility toward the cost of continuation coverage in lieu of paying for the USERRA continuation coverage. When an employee's accumulated eligibility is exhausted, the employee may pay for USERRA coverage under the self-pay rules of this Plan. If the employee does not want to use his accumulated eligibility to pay for USERRA coverage, the employee can choose to freeze it and instead proceed to pay for the USERRA coverage under the self-pay rules of this Plan as described above.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE.

Questions regarding your entitlement to USERRA leave should be referred to your employer. Questions that pertain to continuation of health care coverage during the approved leave should be referred to the Plan Administrator.

After Discharge from the Armed Forces:

When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

WHEN COVERAGE ENDS

Generally, your coverage ends when you fail to work the necessary number of hours to earn coverage. Medical coverage for you and eligible members of your family generally ends on the earliest of the following dates:

- the date you are no longer eligible for coverage (the last day of the Benefit Program period following the Benefit Accrual Period in which you work less than 750 hours),

- the date the plan is modified, eliminating any benefits or participation for your particular class of employee,
- the date of your (the employee's) death, or
- the date the plan is terminated.

Coverage for your dependents ends the earlier of the date your (the **employee's coverage** ends or when a dependent no longer meets the definition of a dependent as follows:

- Coverage for a spouse (and step-children, if applicable) ends the date of the divorce or legal separation from the participant.
- Coverage for dependent children ends the earlier of the last day of the month:
 - in which the dependent child turns age 26;
 - in which the dependent child no longer meets the provisions for continued coverage for a disabled child; or
 - in which legal guardianship or foster relationship is terminated.
- Coverage for dependent parents ends when no longer a dependent of the employee.

You may be eligible for continuation of benefits under COBRA as described in the next section.

Coverage may also be terminated in the event that you (or your dependent) makes a false statement or furnishes fraudulent or incorrect information in order to incorrectly obtain coverage under the Plan. In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when premiums and contributions are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan.

RETIREE PLAN BENEFITS

The Welfare Fund also sponsors a separate, stand-alone Retiree Plan for retired participants who meet the eligibility rules as described below. The benefits are described in the Bricklayers Insurance & Welfare Fund Retiree Plan's Summary Plan Description. When you retire from Active coverage and if you meet the eligibility rules, you will be notified of your eligibility and sent a Summary Plan Description and an enrollment card in order to enroll in the Retiree Plan. Please contact the Fund Office if you would like a copy of the Retiree Plan Summary Plan Description.

Retiree Eligibility: In order to be eligible for benefits under the Retiree Plan of the Insurance and Welfare Fund as a retired participant or a retired regular full-time employee of the Fund Office of the Bricklayers Fringe Benefits Funds, you must meet the following conditions:

- You must apply for and begin receiving a retirement benefit from the Pension and Annuity Plan of the Bricklayers Pension Fund on or after you turn age 60, have earned at least forty

vesting quarters with that plan, and work at least 700 hours of service during any two consecutive years after the year you attained age 52. Or, if you are in receipt of a Social Security disability award and are receiving a disability retirement benefit from the Pension and Annuity Plan of the Bricklayers Pension Fund, you must have earned forty vesting quarters with that plan and worked at least 700 hours of service during two of the seven years before the year Social Security determined you to be disabled.

- you must have worked enough hours to have been eligible for the Plan A Benefit Program during two (2) of the five (5) Benefit Accrual periods preceding retirement (as description in the Summary Plan Description for the active participants of the Bricklayers Insurance and Welfare Fund); and, in order to continue to be eligible for coverage under the Retiree Plan,
- maintain “retired” status membership in the BAC Local Union # 1, NY.

Fringe Benefit Fund Office employees, for the purpose of determining eligibility for retiree benefits, shall have their hours earned as regular full-time employees of the Fund Office after December 31, 1989 to December 31, 2002 considered to be Hours of Service in the Pension and Annuity Plan of the Bricklayers Pension Fund. This will not entitle them to any benefit from the Pension Plan, and will only be used to determine eligibility for a retirement benefit as if their employment met the definition of Covered Employment as defined by the Pension and Annuity Plan of the Bricklayers Pension Fund.

CONTINUATION OF COVERAGE (COBRA)

Entitlement to COBRA Continuation Coverage

Under a federal law – the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – it is required that employers that contribute to group health plans offer employees and certain of their dependents the opportunity for a temporary extension of health coverage (called “Continuation Coverage”), at group rates, in certain instances where coverage under the plan would otherwise terminate. COBRA only applies to health benefits (medical, prescription drug, hospital, dental and optical benefits). The following section summarizes your rights and obligations with respect to COBRA Continuation Coverage. You, your spouse and any adult eligible dependents should read this carefully.

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. You may also qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

This Plan provides no greater COBRA rights than what is required by law and nothing in this section is intended to expand a person’s COBRA rights.

The Fund Office is the COBRA Administrator.

Entitlement to COBRA Continuation Coverage

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage when a Qualifying Event occurs, and as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered employees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment.

Under the law, a "Qualified Beneficiary" is any Employee or the spouse or dependent child of an employee who is covered by the Plan when a qualifying event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a dependent child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

"Qualifying Events" are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, and, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan. If a covered individual has a Qualifying Event but, as a result, does not lose their health care coverage under this Plan, (e.g., employee continues working even though entitled to Medicare) then COBRA is not available.

COBRA Continuation Coverage can continue for up to an initial 18 month period, or, under certain circumstances, for an additional 11 or 18 months depending on the COBRA qualifying event.

The following chart lists the COBRA Qualifying Events and who can be a Qualified Beneficiary:

Qualifying Event Causing Health Care Coverage to End	Qualified Beneficiaries		
	Employee	Spouse	Dependent Child(ren)
Employee terminates (for other than gross misconduct), including retirement or has a reduction in hours paid (making employee ineligible for the same health care coverage.	X	X	X
Employee dies.	N/A	X	X
Employee becomes divorced or legally separated.	N/A	X	X (stepchildren only)
Dependent Child ceases to have Dependent status.	N/A	N/A	X

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage for all the above Qualifying Events listed above is 36 months. The maximum period of COBRA coverage may be cut short for the reasons described in the section on “Early Termination of COBRA Continuation Coverage” that appears later in this section.

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 participant must notify the Fund Office in writing of that event no later than 60 days after that event occurs. The written notice should be sent to:

Bricklayers’ Insurance & Welfare Fund
66-05 Woodhaven Boulevard
Rego Park, NY 11374
Phone: (718) 459-5800

The notice should include your name, the qualifying event, the date of the event and appropriate documentation in support of the event (e.g., divorce documents.)

Please note that in the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the Fund Office will send an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

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.
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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.

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.

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred but you will have to pay for it. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, the same will apply to 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.

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 COBRA Continuation Coverage charge is different in cases of extended COBRA coverage due to Social Security disability. See that section for further information.

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 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 terminate.

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 eleven (11) additional months (for a total of twenty-nine (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 sixty (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 sixty (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 earliest of:

- The last day of the month, thirty (30) days after Social Security has determined that you and/or your dependent(s) are no longer disabled.
- The end of twenty-nine (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 Social Security 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 extension period.

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 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 terminate.

You may pre-pay premiums for COBRA coverage.

You may choose to pre-pay your COBRA premiums for up to 18 months. If you pre-pay and subsequently qualify for active coverage with this Plan at any point during the pre-paid period, the remainder of your pre-paid amount will be refunded to you upon request. If you pre-pay and later decide to terminate your COBRA coverage, the Plan will refund the remainder of the pre-paid amount effective the first of the month following receipt of notice from you requesting termination. For more information on this option, contact the Fund Office.

If you fail to make a monthly payment before the end of the late payment period for that month, your coverage will terminate and you will lose all rights to continuation coverage under the Plan. Once continuation coverage is lost, it cannot be reinstated.

When COBRA Coverage May Be Cut Short

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

- The first day of the time period for which you do not pay the COBRA premiums within the required time period.
- The date on which the Plan 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.
- 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).
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Fund Office determines that COBRA coverage will terminate early.

Once COBRA coverage terminates early it cannot be reinstated.

COBRA Questions or To Give Notice of Changes in Your Circumstances

If you have any questions about your COBRA rights, please contact Fund Office.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify the Fund Office:

- within 31 days of adding a new dependent;
- within 60 days if a dependent no longer meets the definition of dependent;
- promptly if an individual has changed their address, becomes entitled to Medicare, or covered under another group health plan.

SUMMARY OF PLAN BENEFITS

Your coverage under the Plan are generally broken into two parts, Medical coverage (which includes medical, prescription drugs, dental and optical benefits) and Hospitalization benefits. In addition, the Plan provides a death benefit to your beneficiaries which is described in the next section. Each benefit is fully described in separate sections which follow and which can be quickly found in the Table of Contents.

Benefit	Summary of Benefit
<p>Medical Benefits</p> <ul style="list-style-type: none"> • Physician Services including Office visits, Consultations and Immunizations • Annual Physical Examination • Surgical Benefits including Surgical Expense Benefit, Assistant Surgeon Benefits, Anesthesia, and Post-Surgical Hospital Benefits • X-Ray and Laboratory Expense Benefit • 	<p>Benefits are self-insured and administered by the Fund Office. MagnaCare administers the PPO Network.</p> <ul style="list-style-type: none"> • Available from either In-Network or Out-of-Network Providers. • Payable at 100% up to Allowed Amount under the Plan • The Allowed Amount differs for Plan A and Plan B participants
<p>Prescription Drug Benefits</p>	<p>Benefits are self-insured and administered by SavRx Prescription Drug Card Program.</p> <ul style="list-style-type: none"> • <i>Plan A</i> – Benefits are payable at 100% up to \$2,600 in covered expenses • <i>Plan B</i> – Benefits are payable at 100% up to \$1,350 in covered expenses <p>Thereafter, payable at 5% (you pay 95%) of covered expenses.</p>
<p>Dental Benefits</p>	<p>Benefits are self-insured and administered by the Self-Insured Dental Services/Metrodent Network.</p> <ul style="list-style-type: none"> • Available from In-Network or Out-of-Network Providers • Payable at 100% up to Allowed Amount under the Plan <ul style="list-style-type: none"> – <i>Plan A</i> – Benefits are payable at 100% up to \$3,250 in covered expenses – <i>Plan B</i> – Benefits are payable at 100% up to \$2,450 in covered expenses
<p>Optical Benefits</p>	<p>Benefits are self-insured and administered by the Fund Office. Voucher program administered by Vision Screening Program and General Vision Services.</p>
<p>Hospital Benefits</p>	<p>Self-Insured and administered by Empire Blue Cross Blue Shield.</p> <ul style="list-style-type: none"> • Benefits are paid for inpatient and outpatient hospital facility charges and ambulance services

- See the Empire section for details on how this benefit works

Please note that while an expense may not be covered under the Medical benefits, it may be covered under the Hospital benefit. For example, facility expenses are not covered under the Medical Coverage but are covered under the Hospital Benefits.

DEATH BENEFITS FOR ELIGIBLE PARTICIPANTS

Death benefits for active participants are as follows:

<i>Benefit Program</i>	<i>Amount</i>
A	\$15,000
B	\$12,000

Please note that there is only one death benefit payable upon the death of a participant.

If you do not name a beneficiary, or if the person you name dies before you, your death benefit will be paid as follows:

First: to your spouse; or if your spouse is not living,

Second: to your living children in equal shares; or if there are no living children,

Third: to your parents in equal shares; or if neither parent is living, then,

Fourth: to your estate.

Any attempted assignment by the beneficiary will be considered null and void. In such case, the money will be held by the Trustees for such purposes as they in their sole discretion deem proper.

The Trustees reserve the right to pay up to one-half of the amount of the Death Benefit to any person who incurred expenses on behalf of the deceased participant's burial. No benefit shall be payable if proper claim is not made within one year from the date of death of a participant.

*NOTE This excludes new participants granted eligibility as described on page 1.

You should review the tax consequences of this benefit with a tax advisor.

MEDICAL BENEFITS INCLUDING IN-NETWORK BENEFITS PROVIDED THROUGH THE MAGNACARE PPO

Covered Medical Benefits

The Plan provides coverage for Medical benefits that are determined to be Medically Necessary. The expenses for which you are covered are called “covered medical benefits.” Covered medical benefits are eligible medical expenses that are determined by the Plan Administrator or its designee to be, and are limited to those that are:

- **“Medically Necessary,”** but only to the extent that the charges are **“Allowed Charges”** (as those terms are defined in the definitions section of this document); and
- **Not services or supplies that are excluded** from coverage (as provided in the Exclusions section of this document); and
- **Not services or supplies in excess** of any maximum Plan benefit as described in this section; and
- **For the diagnosis or treatment of an Injury or Illness** (except where wellness/preventive services are payable by the Plan).

The Plan will not reimburse you for any expenses that are not covered medical benefits or are not considered eligible medical expenses. That means you are responsible for paying the full cost of all expenses that are not determined to be Medically Necessary, determined to be in excess of the Plan’s Allowed Amount, not covered by the Plan, or in excess of a maximum Plan benefit.

Allowed Amount

The Plan will not always pay benefits equal to or based on the provider’s actual charge for health care services or supplies. This is because the Plan covers only the “Allowed Amount” for health care services or supplies. Participants are always responsible for amounts that exceed the “Allowed Amount” by this Plan. This is also known as balance billing.

The Allowed Amount means the amount this Plan allows as payment for eligible Medically Necessary covered medical services or supplies. The Allowed Amount is determined by the Board of Trustees or its designee and means the schedule that lists the dollar amounts the Plan has determined it will allow for covered medical benefits. Where an In-Network provider has agreed to accept the Plan’s Allowed Amount as payment in full, the negotiated fee/rate set forth in the agreement between the participating provider and MagnaCare or SIDS will be considered the Allowed Amount. If the providers actual billed charges are lower than the scheduled or negotiated amount, the billed charges will be considered the Allowed Amount.

The Plan’s Allowed Amount is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim.

The MagnaCare Preferred Provider Organization (PPO) Medical Network (In-Network Benefits)

You may choose to use any provider you want. However, if you receive medical services or supplies from a health care provider that has a contract with the MagnaCare Network, you will be responsible for paying less money out of your pocket. The Plan's Preferred Provider Organization (PPO) is MagnaCare which is a network of physicians, laboratories and other health care providers who have agreed to provide health care services and supplies for favorable negotiated discount fees applicable only to Plan participants. Health care providers who are under a contract with the MagnaCare Network have agreed to accept the discounted amount the Plan pays for most covered services (with the exception of certain visits/consultations, immunizations and complex surgeries) as payment in full. For MagnaCare Network providers who accept the Plan's allowance, you will have no out-of-pocket expense (and the service will be paid in full by the Plan). If a providers does not accept the Plan's allowance, you will be billed by the provider and must pay the provider directly.

The MagnaCare network consists of more than 70,000 industry-leading healthcare provider locations in the New York and New Jersey area and if you live or travel to another state, you can access over 500,000 healthcare providers through First Health, MagnaCare's National Access network. This network of physicians covers specialists ranging from internists and other family doctors to various types of surgeons. Additionally, MagnaCare's networks include hospitals, diagnostic facilities, laboratory facilities and radiology facilities, as well as ancillary providers. If you or a member of your family are living or traveling outside of the New York & New Jersey area you have access to In-Network providers nationally through MagnaCare's National Access network. To find a participating provider please call (800) 226-5116 or visit www.myfirsthealth.com.

Directories of Network Providers: Providers who participate in the MagnaCare Network are added and deleted during the year. At any time, you can find out if any provider is a member of MagnaCare by visiting www.MagnaCare.com or by calling (516) 282-8244. Because health care providers are added to and deleted from networks during the year you should call MagnaCare or ask the provider to verify their contracted network status before your visit to assure you will be able to receive their discounted price for the services you need.

Keep in mind the following in order to receive the maximum reimbursement from the Plan:

- Check the MagnaCare Network Provider Directory on MagnaCare's website or call MagnaCare directly at (516) 282-8244 for the nearest network provider. The directory lists Physicians according to location and type of practice. You may request a copy of the provider list, free of charge, by contacting MagnaCare.
- Select a Physician from the network and schedule an appointment. Verify that he or she is participating in the MagnaCare Network. Remember, because providers are periodically added to and dropped from the PPO network throughout the year, it is best if you ask your health care provider if they remain In-Network with MagnaCare or contact MagnaCare each time before you seek services.

Although you may choose any Physician listed, it is recommended that you select a family Physician (or general internist or general pediatrician) as your primary care provider. Should you

need a specialist, your primary care Physician would be in a better position to advise you about what type of specialist would be most appropriate for your medical condition. Keep in mind that it is still your responsibility to ensure such providers are In-Network.

Out-of-Network (Also Called Non-Network, Non-PPO or Non-Participating)

These terms refer to providers who are not contracted with the MagnaCare Network. These Out-of-Network health care providers may bill a Plan participant a non-discounted amount for any balance that may be due in addition to the Allowed Amount payable by the Plan. To avoid or minimize balance billing, you should use In-Network Providers.

Women's Health and Cancer Rights Act

This Plan complies with the Women's Health and Cancer Rights Act (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications for all stages of mastectomy, including lymphedemas.

To the extent permitted by applicable law, this coverage is subject to applicable copays, referral requirements, annual deductibles and coinsurance provisions that may apply under the Plan. If you have any questions, please contact the Fund Office.

Newborns' and Mothers' Health Protection Act

This Plan complies with the protections afforded under the Newborns' and Mothers' Health Protection Act of 1996, which prohibits group health plans and health insurance issuers from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's and newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or MagnaCare for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Genetic Information Non-Discrimination Act (GINA)

Effective June 1, 2009, GINA prohibits discrimination by group health plans such as the Fund against an individual based on the individual's genetic information. Group health plans and health insurance issuers generally may not request, require or purchase genetic information for underwriting purposes, and may not collect genetic information about an individual before the individual is enrolled or covered. Pursuant to the applicable requirements of GINA, the Fund is also prohibited from setting premium and contribution rates for the group on the basis of genetic information of an individual enrolled in the Fund.

COVERED MEDICAL BENEFITS

PHYSICIAN SERVICES

A participant or eligible dependent may select a legally qualified physician of his own choice.

Office, In-Hospital Visits and Urgent Care

Coverage for office visits includes visits for well-baby, well child, podiatrist, mental health and substance abuse disorders as follows:

- **Benefit Program A and B:** The Plan will pay 100% of eligible medical expenses up to \$75 per visit to a physician. Generally, MagnaCare Network providers will accept this amount as payment in full. For out-of-network providers (and those MagnaCare Network providers who do not accept the Plan's allowance), you will be responsible for any balances over the Allowed Amount. Please note, chiropractic office visits are covered for members only, spouses and other dependents are not covered.

Consultations

The Plan covers consultation visits to specialists and physician services for pulmonary and cardiac rehabilitation as follows:

- **Benefit Program A:** The Plan will pay 100% of eligible medical expenses up to \$150 per visit. You are responsible for any amounts over the Allowed Amount.
- **Benefit Program B:** The Plan will pay 100% of eligible medical expenses up to \$100 per visit. You are responsible for any amounts over the Allowed Amount.

For out-of-network providers (and those MagnaCare Network providers who do not accept the Plan's allowance), you will be responsible for any balances over the Allowed Amount.

Immunizations

The Plan will cover immunizations as follows:

- **Benefit Program A and B:** The Plan will pay 100% of eligible medical expenses up to \$50 per immunization plus 100% of the charges for the administration of the immunization up to \$50 per immunization.. You are responsible for any amounts over the Allowed Amount.

ANNUAL PHYSICAL EXAMINATION

You are eligible for one physical exam per year. A participant or eligible dependent may select a legally qualified medical diagnostic facility of his own choice. The Plan will pay 100% of the allowed amount eligible medical expenses for one annual physical per year.

You may also use the services of PMEG for your physicals. In order to make an appointment for an Annual Physical, contact PMEG at 800-811-7364.

SURGICAL BENEFITS

Surgical Expense Benefit

The Plan covers expenses associated with Medically Necessary surgery. In order to be covered by the Plan, the surgery must be recommended, approved and performed by a legally qualified physician or surgeon. Surgical benefits are provided regardless of where the surgery is performed (whether on an inpatient or outpatient basis). Keep in mind that while the physician fees for the surgery are payable under the Medical benefit, facility fees are payable under the Hospital benefit. (See the Hospital section for details.)

The Plan will cover eligible medical expenses associated with Medically Necessary surgery as follows:

- ***Benefit Program A:*** The Plan will pay 100% of the Allowed Amount as listed in the Schedule of Surgical Operations Reimbursement up to a maximum of \$10,000 per surgery. You are responsible for any amounts over the Allowed Amount.
- ***Benefit Program B:*** The Plan will pay 100% of the Allowed Amount as listed in the Schedule of Surgical Operations Reimbursement up to a maximum of \$7,000 per surgery. You are responsible for any amounts over the Allowed Amount.

The Plan maintains a schedule of Surgical Operations Reimbursement that lists the Allowed Amount for surgical procedures by Current Procedural Terminology (CPT®) code. If you wish to obtain a specific allowance, please contact the Fund Office and they can provide you with the Allowed Amount for a specific CPT® code.

For out-of-network providers (and those MagnaCare Network providers who do not accept the Plan's allowance), you will be responsible for any balances over the Allowed Amount.

If two or more operations are performed through the same incision, the amount payable will be for the operation for which the largest benefit is payable. If more than one related operation is performed at any one time, the total payment for all such operations shall not exceed one and one-half times the maximum payment specified in the Plan's Schedule of Surgical Operations Reimbursement for the one operation for which the largest amount is payable.

Assistant Surgeon Benefit

If you or an eligible dependent undergoes an operation for which Surgical Benefits are payable by this Fund and for which an Assistant Surgeon is Medically Necessary, you are eligible for Assistant Surgeon Benefits as follows:

- ***Benefits Program A:*** the amount of the Assistant Surgeon Benefit is 30% of the amount payable by the Plan for the surgery.
- ***Benefit Program B:*** the Assistant Surgeon Benefit is 25% of the amount payable for the surgery.

For out-of-network providers (and those MagnaCare Network providers who do not accept the Plan's allowance), you will be responsible for any balances over the Allowed Amount.

Anesthesia Benefits

If you or an eligible dependent undergoes an operation for which Surgical Benefits are payable by this Fund, you are eligible for Anesthesia Benefits for anesthesia charges. This benefit is paid only if the anesthesia is administered by an anesthesiologist (medical doctor or registered nurse) other than the operating surgeon or by a paid employee of the hospital as follows:

- **Benefit Program A:** The Plan will pay 80% of the billed amount for the anesthesia to a maximum of \$3,000 per surgery.
- **Benefit Program B:** The Plan will pay 80% of the billed amount for anesthesia to a maximum of \$2,000 per surgery.

Post-Surgical Hospital Benefits

In addition to benefits payable for the actual surgical operation, the plan provides a Post-Surgical Hospital Visits Benefit. If you or your eligible dependent undergoes an operation for which Surgical Benefits are payable by this Fund and which require Medically Necessary visits by your surgeon after the operation and while still in the hospital, the plan will cover qualified amounts up to 20% of the amount payable under the Surgical Benefit. In no event, however, will reimbursement exceed the actual charge for the post-surgical visits. For out-of-network providers (and those MagnaCare Network providers who do not accept the Plan's allowance), you will be responsible for any balances over the Allowed Amount.

X-RAYS AND LABORATORY EXPENSE BENEFITS

If you or an eligible dependent has an x-ray or laboratory examination, a procedure or treatment by or at the request of a legally qualified physician or surgeon, you will receive benefits in accordance with the Schedule of X-Ray and Laboratory Examination for each x-ray or laboratory examination, procedure or treatment, including radiation therapy. This benefit will be paid in connection with x-ray and laboratory procedures not requiring hospital confinement. If you are an inpatient in a hospital or receive services in an outpatient hospital department or facility, such services and supplies are payable by the Empire under the Hospital Benefit.

The Plan will cover eligible medical expenses for X-ray and Laboratory as follows:

- **Benefit Program A and B:** The Plan will pay 100% of eligible medical expenses up to the Allowed Amount as listed in the Schedule of X-Ray and Laboratory Examination. You are responsible for any amounts over the Allowed Amount. Chemotherapy, cobalt and related treatments for malignant disease are covered to a maximum of \$250 per treatment. No benefit will be paid for interpretation fees.

The amount of X-ray and Laboratory Expense Benefits paid shall not exceed the amount actually charged nor shall it be in excess of the amount specified for the x-ray or laboratory examination, procedures or treatment in the Schedule of X-ray and Laboratory Examinations. X-ray and Laboratory Expense Benefits by or at the request of a Doctor of Podiatry will be paid only in connection with foot conditions for which benefits are payable. For out-of-network providers (and those MagnaCare Network providers who do not accept the Plan's allowance), you will be responsible for any balances over the Allowed Amount.

If you wish to obtain a specific allowance for an x-ray or laboratory expense, please contact the Fund Office and they can provide you with the Allowed Amount for a specific CPT® code.

Interpretation fees are covered up to allowed plan maximums.

EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES

Allergy/Alternative/Complementary Health Care Services Exclusions Expenses for:

Acupuncture and/or acupressure; chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron; prayer/faith, religious healing, or spiritual healing; services performed by or tests/supplies ordered or provided by a naturopathic, naprapathic and/or homeopathic provider; for experimental/investigational/unproven allergy treatments including but not limited to sublingual (under the tongue) drops/oral antigen, rhinophototherapy (use of ultraviolet lights as a treatment for allergic rhinitis and other nasal conditions), repository emulsion therapy (a form of therapy where certain materials are placed inside the body to improve allergies).

Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions:

Expenses for any corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment and non-durable supplies. Expenses for durable medical equipment and nondurable supplies may be submitted under the Special Benefit for consideration for payment in accordance with the rules of the Special Benefit (as described in the next section). However, no expenses are payable for breast pumps under any circumstances.

Cosmetic Services Exclusions: Surgery or medical treatment to improve or preserve physical appearance, but not physical function as determined by the Plan Administrator or its designee. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons. The Medical Program **does** cover Medically Necessary Reconstructive Services.

Custodial Care Exclusions: Expenses for custodial care regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service.

Fertility and Infertility Services Exclusions

- Expenses for the treatment of infertility along with services to induce pregnancy and complications thereof, including, but not limited to services, prescription drugs, procedures or devices to achieve fertility, expenses for and related to the pregnancy, delivery fees and complications for the woman who is the surrogate even if the surrogate is a covered individual and reversal of sterilization procedures.
- Expenses for and related to adoption.

Genetic Testing and Counseling Exclusions

- **Genetic Testing:** The following expenses for genetic tests are not covered, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics:
 - Pre-parental genetic testing (also called carrier testing) intended to determine if an individual (such as a prospective parent) is at risk of passing on a particular genetic mutation (at risk for producing affected children).;
 - Expenses for Pre-implantation Genetic Diagnosis (PGD) where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization;
 - No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the medically necessary treatment of a plan participant;
 - Home genetic testing kits/services are not covered.
 - Genetic testing determined by the Plan Administrator or its designee to be not medically necessary or is determined to be experimental or investigational.

Genetic Counseling: Expenses for genetic counseling are not covered

Hair Exclusions: Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees, hair prosthesis and/or hairpieces or hair analysis, except that the Plan will provide benefits for a single wig, toupee or hairpiece if it is required to replace hair lost as a result of chemotherapy as described in the Corrective Appliances section of the Schedule of Medical Benefits.

Hearing Care Exclusions: Expenses for and related to the purchase, servicing, fitting and/or repair of hearing aid devices, including, implantable hearing devices such as cochlear implants. Expenses for hearing aids and their fitting may be submitted under the Special Benefit for consideration for payment in accordance with the rules of the Special Benefit.

Maternity/Family Planning/Contraceptive Exclusions

- **Home Delivery:** Expenses for pre-planned home delivery.
- Expenses for **childbirth education, Lamaze classes, and breast-feeding/lactation** classes.
- Expenses related to the **maternity care and delivery expenses associated with a surrogate mother's pregnancy, delivery and complications.**
- Expenses related to **cryostorage of umbilical cord blood or other tissue or organs.**

Nursing Care Exclusions: Expenses for services of private duty nurses/health care personnel.

Outpatient rehabilitative services (including but not limited to physical therapy, occupational therapy, cardiovascular and respiratory rehabilitation, speech therapy). Expenses for physical therapy, occupational therapy and chiropractic services may be submitted under the Special Benefit for consideration for payment in accordance with the rules of the Special Benefit.

Prophylactic Surgery or Treatment Exclusions

Expenses for all medical or surgical services or procedures, including prescription drugs and the use of Prophylactic Surgery as defined in the Definitions section of this document, when the services, procedures, prescription of drugs, or Prophylactic Surgery is prescribed or performed for the purpose of:

- avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or
- treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, except when the services or procedures are specifically designated covered medical expenses in the Schedule of Medical Benefits, and/or when the services or procedures are based on the results of amniocentesis, chorionic villus sampling (CVS), or alphetoprotein (AFP) analysis.

Rehabilitation Therapy Exclusions (Outpatient): Expenses for educational, job training, vocational rehabilitation, respite care or recreational therapy.

Treatment of Erectile Dysfunction (Impotency): Expenses for prescription drugs (*e.g.* Viagra, Cialis) and/or medical or surgical treatment of erectile dysfunction or inadequacy, and any complications thereof, except that erectile dysfunction drugs are payable when FDA approved and prescribed by a physician as treatment for a medical condition like benign prostatic hypertrophy or BPH.

Smoking Cessation or Tobacco Withdrawal Exclusions: Expenses for tobacco/smoking cessation products such as nicotine gum or patches, or other services or programs.

Transplant (Organ and Tissue) Exclusions

- Expenses for human organ and/or tissue transplants that are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, postoperative services and drugs/medicines and all complications thereof, except those Transplant Services and their complications that are listed as payable under Transplantation in the Schedule of Medical Benefits.
- Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves.
- Expenses for insertion and maintenance of an artificial heart or other organ or related device including complications thereof, except heart valves, kidney dialysis, and a ventricular assist

device (VAD) (that is a mechanical pump used to assist a damaged or weakened heart in pumping blood) only when used as a bridge to a heart transplant or for support of blood circulation post-cardiotomy (following open-heart surgery, or for destination therapy (permanent mechanical cardiac support only if there is approval from the FDA for that purpose, and the device is used according to the FDA-approved labeling instructions).

- For plan participants who serve as a donor, donor expenses are not payable by this Plan unless the person who receives the donated organ/tissue is a person covered by this Plan.

Weight Management and Physical Fitness Exclusions

- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, fitness instructors, work hardening and/or weight training services or exercise/activity/health monitoring/tracking devices, or software applications including smartwatches/jewelry and wireless or wearable sensors trackers.

SPECIAL BENEFITS

The Plan offers participants (and family members who are eligible and enrolled dependents) a Special Benefit designed to permit participants to obtain reimbursement of certain eligible expenses that might not otherwise be covered by the Plan. However, your eligible dependents are only eligible for the Special Benefit if you are also eligible for and enrolled in the Plan. For each Benefit Period you are eligible under the Plan, you will be eligible for reimbursement of eligible medical expenses payable under the Special Benefit for up to \$2,000 during the Benefit Period. Each Benefit Period commences on April 1st and ends on the following March 31st. If you do not use the entire \$2,000 during the any given Benefit Period, it will not carry forward and you will forfeit any remaining balance.

Eligible Medical Care Expenses. The Special Benefit can be used for reimbursement of the following medical care expenses that might not otherwise be covered under the Plan. These are the ONLY benefits that are payable under the Special Benefit.

- Expenses for hearing aid device(s) as ordered by a physician.
- Covered charges for replacement of blood and its transfusion not covered by Empire HealthChoice under the Hospital benefit. No benefits are payable for the replacement of blood, if blood has been donated in exchange for payment.
- Covered charges for oxygen and use of an oxygen tent.
- Covered charges for Medically Necessary nondurable supplies dispensed and used by a physician in conjunction with treatment of the covered individual including the cost of crutches.
- Covered charges for rental (but only up to the allowed amount for the purchase price of) durable medical equipment (DME) when its use is Medically Necessary and ordered by a physician including rental cost of a hospital bed for use at home.
- Covered charges by a registered graduate nurse (RN) or a licensed practical nurse (LPN), at home or when confined in a hospital, other than a staff nurse in the institution where confined, when ordered by a legally qualified physician. No benefits are payable for charges by a nurse who ordinarily resides in an employee's household or is a participant of his immediate family.
- Covered charges for outpatient rehabilitative services (including but not limited to physical therapy, occupational therapy, cardiovascular and respiratory rehabilitation, and speech therapy) up to the Allowed Amount under the Plan.
- Chiropractic care that exceeds the annual number of visits covered under the Plan.
- Ambulance transportation not otherwise covered under the Plan.

How to File a Special Benefit Claim. In order to be reimbursed, the provider must contact the fund office and provide a letter of medical necessity to be reviewed and approved by the fund office for a special benefit allowance. The fund office will provide a letter of authorization upon review and approval for services requested.

- Completed and signed claim form (that includes an acknowledgement that the expense has not been reimbursed and is not reimbursable under any other source) that describes the person or persons on whose behalf expenses have been incurred, a description of the expense incurred, the date the expense was incurred and the amount of the requested reimbursement; and copy of the Explanation of Benefits (EOB) for the expenses you are requesting reimbursement for or bills, invoices, or other statements from an independent third party (e.g., physician or other health care provider) showing that the expense(s) have been incurred and the amounts of such expense, together with any additional documentation that the Fund Office may request.

The Plan will not reimburse you for any expenses if such expenses have been reimbursed by any other health care insurance, plan, provider or entity. If only a portion of an expense has been reimbursed elsewhere (e.g., because another plan paid part of the expense), the Special Benefit can reimburse the remaining portion of such expense if it otherwise meets the requirements described above. Reimbursements are payable only to you, the participant, not to an insurance company or medical provider.

Claims for the Benefit Period can be submitted at any time after an expense is incurred, but in no event later than June 30th of the following year in which the claim was incurred. If you do not submit claims by this date, you will not be able to submit a claim for that Benefit Period.

Reimbursements after Termination and COBRA. You will not be able to receive reimbursements under the Special Benefit after your coverage terminates. Claims can be reimbursed after the date of termination only if you purchase COBRA continuation coverage and have a balance under the Special Benefit.

Exclusions

No expense are payable under the Special Benefit unless they meet the definition of “medical care” under Code § 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs and are listed as a covered Eligible Medical Care Expense in the section above. No other expenses are payable from this benefit. In no event are any premiums for individual health insurance a permissible plan benefit, whether purchased in the individual insurance market or in a Health Insurance Marketplace

Some notes on the Special Benefits: The Special Benefit is intended to qualify as an integrated health reimbursement arrangement (HRA) under §105 and §106 of the Internal Revenue Code of 1986, as amended, and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Special Benefit is funded in the same way as other benefits under this Plan, with employer contributions only. You may not contribute to your own Special Benefit.

Opt-Outing Out of the Special Benefit: You may permanently opt out of and waive future reimbursements from the Special Benefit once per year by contacting the Fund Office and filling out an opt-out form.

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits are provided under the SavRx prescription card program.

SavRx provides a nationwide network of retail pharmacies that will fill your prescriptions as a *participating* pharmacy. You receive prescription drug coverage when you go to a pharmacy that is not participating in this network, but you may have to make a higher out-of-pocket payment than if you use a participating pharmacy. Your identification card and your prescription are all you need to obtain prescription service at a participating pharmacy. All participating pharmacies have the necessary claim forms. If you obtain prescription drugs at a non-participating pharmacy, you will have to pay the charge, then complete a claim form to receive reimbursement. You may obtain a claim form from the Fund Office. Complete a claim form for each prescription and attach the receipt and mail it to SavRx.

If a licensed medical doctor, dentist or osteopathic physician prescribes drugs for you or an eligible dependent, you may be eligible for Prescription Drug Benefits.

Benefits under this section are limited to the following Prescription Drugs only:

1. Prescriptions which require compounding;
2. Prescriptions for Legend Drugs (drugs which cannot be dispensed without a prescription);
3. Insulin on prescription.

The Plan will pay for insulin but will not pay for companion implements such as hypodermic syringes, needles, etc. The Plan will not cover any drugs, vitamins, diet supplements, etc. which can be purchased without a prescription. The fact that a physician may give you a written prescription for items of this type will make no difference.

The combined maximum prescription drug benefit payable per family for a Benefit Program is as follows:

Benefit Program A: Plan pays 100% of expenses up to \$2,600, thereafter Plan pays 5% (you pay 95%) of covered expenses

Benefit Program B: Plan pays 100% of expenses up to \$1,350, thereafter Plan pays 5% (you pay 95%) of covered expenses

In addition, if you are covered under another prescription plan you may submit your co-payments for reimbursement.

Prescription Benefit Drugs, Medicines and Nutrition Exclusions

Notwithstanding the foregoing, the following drugs are NOT covered under this Plan:

- Pharmaceuticals requiring a prescription that have not been approved by the US Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route, duration and frequency for which they are prescribed (*i.e.* are used “off-label”; or are Experimental and/or Investigational.
- Non-prescription (or non-legend or over-the-counter) drugs or medicines, except certain types of insulin.

- Drugs requiring a prescription by state law, but not by federal law.
- Foods and nutritional/dietary supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription).
- Naturopathic, naprapathic or homeopathic products and substances.
- Vaccinations, immunizations, inoculations or preventive injections, including immunizations needed due to foreign/international travel such as for yellow fever or to protect against occupational hazards and risks.
- Drugs, medicines or devices for:
 - diabetic blood glucose testing supplies such as lancets, teststrips, alcohol swabs;

DENTAL CARE BENEFITS

If you or an eligible dependent requires dental care, you are eligible for Dental Care Benefits from a Self-Insured Dental Services/Metrodent Network provider or a provider of your choice. For a complete description of the Metrodent PPO and/or the location of a Metrodent National Doctor, please contact the Fund Office or S.I.D.S./Metrodent at 516-396-5500 or 718-204-7172 or at www.asonet.com.

Dental Care benefits are treated as a standalone (or excepted) benefit under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Patient Protection and Affordable Care Act (PPACA) as they are separately administered by S.I.D.S./Metrodent.

Dental Care Benefits will be paid in accordance with the Self-Insured Dental Services/Metrodent Schedule of Dental Care Benefits. If you use a Network provider, benefits will be paid at 100% up to the annual maximum listed below. If you use an Out-of-Network provider, you will be responsible for the amount over the Schedule of Dental Care Benefits and the provider's actual charges. In no event are benefits paid in excess of the amount actually charged, nor will benefits be paid if the patient does not incur an actual charge by a licensed dentist, nor will reimbursement be made for any amounts for which you are not legally liable in the absence of coverage by this Fund. Contact the Fund Office or Metrodent in order to determine if a specific procedure is covered and for the Plan's allowance.

The annual maximum amount payable for Dental Care Benefits for a covered individual during a full year Benefit Program Period is \$3,250 for Program A, and \$2,450 for Program B. This maximum does not apply to pediatric dental benefits. Pediatric dental benefits are payable for any individual covered by the plan up to the first day of the month following the month in which he or she turns age 19.

Note: Oral Surgery: Claims for oral surgery that requires hospitalization are covered by the general surgical schedule. There will not be additional payments made under the Dental Benefit. If you must be hospitalized for oral surgery, contact the Fund Office for the surgical allowances. Also note that the surgery must be performed by a legally qualified medical doctor, physician or surgeon.

Filing Claims

When you need to file a claim, notify the Fund Office or your local Union Office and you will be sent the required Dental Care claim form. All claims forms must be completed and returned to Metrodent within 90 days after all dental work is completed.

DENTAL CARE BENEFIT EXCLUSIONS

The following benefits are not payable under the Dental Care benefit:

- **Duplicate or Replacement Bridges, Dentures or Appliances:** Expenses for any duplicate or replacement of any lost, missing or stolen Bridge, Denture or Orthodontic Appliance other than replacements described in the Major Services section of the Schedule of Dental Benefits
- **Duplication of Dental Services:** If a person covered by this Plan transfers from the care of one Dentist to the care of another Dentist during the course of any treatment, or if more than

one Dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount that it would have been liable had but one Dentist rendered all the services during each course of treatment, nor will the Plan be liable for duplication of services.

- **Gnathologic Recordings for Jaw Movement and Position:** Expenses for gnathologic recordings (measurement of force exerted in the closing of the jaws) as performed for jaw movement and position.
- **Education Services and Home Use Supplies:** Expenses for dental education such as for plaque control, oral hygiene or diet or home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick type device, fluoride, mouthwash, dental floss, etc.
- **Hospital Expenses Related to Dental Care:** Expenses for hospitalization related to Dental Surgery or care.
- **Implantology:** Expenses related to implantology (items that serve as artificial or replacement root structures placed into the jaw to support/anchor replacement teeth, bridgework, dentures or other dental prostheses) including, but not limited to, tooth transplants or tooth implants, also referred to as dental implants or endosseous implants.
- **Mouth Guards:** Expenses for athletic mouth guards and associated devices.
- **Expenses for any dental services or appliances to increase vertical dimension,** restore occlusion, stabilize tooth structure lost by wear or bruxism (clenching/grinding of teeth) and devices for harmful habits such as thumb-sucking.
- **Myofunctional Therapy:** Expenses for myofunctional therapy.
- **Periodontal Splinting:** Expenses for periodontal splinting (tying two or more teeth together when there is bone loss to gain additional stability).
- **Personalized Bridges, Dentures, Retainers or Appliances:** Expenses for personalization or characterization of any Dental Prosthesis, including but not limited to any Bridge, Denture, Retainer or Appliance.
- **Services Not Performed by a Dentist or Dental Hygienist:** Expenses for dental services not performed by a Dentist (except for services of a Dental Hygienist that are supervised and billed by a Dentist and are for cleaning or scaling of teeth or for fluoride treatments).
- **Space Maintainers, Study Models, etc.:** Expenses for anterior space maintainers, study models, molds and/or casts.
- **Treatment of Jaw or Temporomandibular Joints (TMJ):** Expenses for prevention of treatment, by any means, of jaw joint problems including temporomandibular joint (TMJ) dysfunction, disorder, or syndrome except to the extent payable under the Schedule of Medical Benefits, and any other craniomandibular disorders or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues relating to that joint.

- Any treatment or service for which you have **no financial liability or that would be provided at no cost** in the absence of dental coverage.
- **Gold Restorations**, unless the tooth cannot be restored with other types of restorative materials.
- **Precision or semi-precision attachments for prosthetic devices.** Conventional appliances are payable.
- **Root canal when used to facilitate appliance placement.**
- **Bacteriologic studies and susceptibility testing** for dental caries (cavities) not covered.
- **Services performed on deciduous teeth near exfoliation.**
- **Services that are an integral component of a covered treatment (e.g. unbundling).**
- **Fees charged for infection control procedures** and compliance with Occupational Safety and Health Administration (OSHA) requirements.
- **Expenses related to complications of a non-covered service.**
- Expenses for and related to **cryostorage of peripheral stem cells in teeth or other tissue.**

OPTICAL CARE BENEFITS

You and your dependents may go to a licensed Optometrist or Ophthalmologist of your choice for an examination once every year. Optical Prescription benefits are covered only if at least one calendar year has elapsed since the last reimbursement from this Fund for optical prescriptions.

Optical Care benefits are treated as a standalone (or excepted) benefit under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Patient Protection and Affordable Care Act (PPACA). Participants may elect/decline vision care benefits annually. If you wish to opt-out of vision benefits, contact the Fund Office.

The Plan has contracted with General Vision Services (GVS) and Vision Screening to provide you with access to their networks of providers. You and your eligible dependents have the option to select either a GVS or Vision Screening provider. The following information in this section describes how the vision benefits, including if you choose an out-of-network provider.

A listing of providers will be furnished to you, free of charge, upon request to the Fund Office. Since providers join and drop out of the network, the best place to go for the most up-to-date information is the provider's website or call GVS, or Vision Screening.

Eligible Vision Care Expenses

The Plan covers the following eligible vision care expenses:

- Eye examinations performed by a legally qualified and licensed ophthalmologist or optometrist
- Prescribed corrective lenses you receive from a legally qualified and licensed optician, ophthalmologist or optometrist
- Glasses and other corrective lenses are available up to the Plan's maximum or at a significant discount, depending on your selection.

Frequency and/or dollar limits may apply to some services and supplies. Refer to materials provided by GVS and Vision Screening for details.

You will be reimbursed for Optical care according to the schedule shown below for covered optical expenses you submit to the Fund Office:

SCHEDULE OF OPTICAL CARE BENEFITS

	Plans A and B
Examination	\$30
Single lens prescription	\$45
Bifocal or trifocal lens prescription	\$60
Frames	\$20

This maximum allowance described above does not apply to pediatric optical benefits. Pediatric optical benefits are payable for any individual covered by the plan up to the first day of the month following the month in which he or she turns age 19.

Participants in Benefit Programs A or B may receive benefits from a Vision Screening provider by requesting a Vision Screening Coupon from the Fund Office. This coupon entitles the Bricklayer or his eligible dependents to a paid in full eye exam, lenses and frames at a participating vision care center. However, only select lens frame models are provided at no cost. Each participant and dependent may use one coupon per year. If you purchase lenses that are not part of the program, you will be responsible for amounts over the scheduled amount as described above. You may also use any provider and submit the bill to the Fund Office. No other Optical benefits will be covered other than what is listed in this section.

PART B AND PART D PREMIUM MEDICARE REIMBURSEMENT

When you become eligible for and enrolled in Medicare Part B, you are entitled to reimbursement of a portion of the Medicare Part B (for retiree only) and Part D (for retiree and Spouse only) monthly premiums in the amount approved by the Board of Trustees. No benefits will be payable for a period prior to the month of January of the calendar year during which the application is received at the Fund Office, regardless of when initial eligibility for Medicare was established. You must obtain an application form from the Fund Office. Once you have submitted a complete application and proof of eligibility for Medicare, you may be entitled to reimbursement benefits.

GENERAL PLAN EXCLUSIONS

The following is a list of services and supplies or expenses **not covered (excluded) by 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 determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. General Exclusions are listed first followed by specific medically related plan exclusion.

GENERAL EXCLUSIONS (applicable to all medical, prescription and/or dental services and supplies):

- **Costs of Reports, Bills, etc.:** Expenses for preparing or completing forms, medical/dental reports/records, bills, disability/sick leave/claim forms and the like; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, e-mailing charges, prescription refill charges, disabled person license plates/automotive forms, interest charges, late fees, mileage costs, provider administration fees, concierge/retainer agreement fees, membership/surcharge fees or provider's special plan charging fees to access added benefits and/or photocopying fees.
- **Educational Services:** Even if they are required because of an injury, illness or disability of a covered individual, the following expenses are not payable by the Plan: educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices.
- **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan benefit limitation or maximum as described in this document.
- **Expenses Exceeding Allowed Amount:** Any portion of the expenses for covered medical services or supplies exceed the Allowed Amount as defined in this document.
- **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay are not covered. Expenses (past, present or future) for which another party is required to pay (e.g. no fault, personal injury protection, etc.) are not covered. See the provisions relating to Third Party Liability in the section on Coordination of Benefits in this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
- **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under this Plan; or after the date the patient's coverage ends, except under those conditions described in the COBRA section of this document.

- **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined to be experimental and/or investigational or unproven as defined in the Definitions section of this document.
- **Military service related injury/illness:** If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.
- **Illegal Act:** Services, supplies or expenses incurred in the treatment of any condition, injury or disability that has arisen from participation in, or commission or attempted commission of, a felony, or criminal act that endangers their health. This provision does not apply if the condition, injury or disability results from being the victim of domestic violence, or if the commission of the illegal act was a direct result of an underlying health factor.
- **Medically Unnecessary Services:** Services or supplies that are not Medically Necessary as defined by this Plan except for the annual physical benefit.
- **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a covered individual, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc.
- **No-Cost Services:** Expenses for services rendered or supplies provided for which a covered individual is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.
- **Services Not Prescribed by a Physician/Provider:** Expenses for services/supplies that are not recommended or prescribed by a Physician, except for those covered services provided by a licensed or certified provider that is covered by this plan.
- **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a health care provider, covered individual or family member of a covered individual.
- **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. This exclusion applies:
 1. even if you or your covered Dependent were not covered by workers' compensation insurance, or
 2. if the covered individual's rights under workers' compensation or occupational disease or similar law has been waived or qualified, or

3. if the covered individual's rights under workers' compensation or occupational disease or similar law would have been available but are not because of some action or inaction the Covered Individual did or did not take.†

- **Personal Comfort Items:** Expenses for patient convenience, comfort, hygiene, or beautification including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, DVD/Compact disc (CD) and other similar devices, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, or private room (only as Medically Necessary), etc.
- **Relatives Providing Services:** Expenses for services provided by any Physician or other health care provider who is the parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant.
- **Medical Students or Interns:** Expenses for the services of a medical student or intern.
- **Stand-By Physicians or Health Care Practitioners:** Expenses for any Physician or other health care provider who did not directly provide or supervise medical services to the patient, even if the Physician or health care provider was available to do so on a stand-by basis.
- **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States.
- **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by any Covered Individual as a result of failure to comply with medically appropriate treatment.
- **Telephone Calls:** Expenses for any and all telephone calls between a Physician or other health care provider and any patient, other health care provider, or any representative of the Plan for any purpose whatsoever, including, without limitation: communication with any representative of the Plan for any purpose related to the care or treatment of a covered individual, consultation with any health care provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; providing counseling to anxious or distraught patients or family members.
- **Internet/Virtual Office/Telemedicine Services:** Expenses related to an online internet consultation with a Physician or other health care provider, also called a virtual office visit/consultation, web visit, Physician-patient web service or Physician-patient e-mail service, telemedicine (real time or store and forward types), telehealth, e-health, e-visit, remote diagnosis and treatment, real-time video-conferencing including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet provider.
- **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

- **Expenses related to complications of a non-covered service.**
- Expenses for and related to **Service animals**, including an animal that has been individually trained to do work or perform tasks for the benefit of an individual with a disability, such as seeing eye dogs, or other disability-assistance dogs/birds/miniature horses and the like, seizure detection animals, diabetes/low blood sugar detection animals, service monkeys, etc. The Plan also excludes service animal supplies, transportation and veterinary expenses.
- Expenses for **services and supplies associated with a clinical trial**, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
- **Untimely Filed Claims:** Expenses for services or supplies that would otherwise be covered by the Plan will not be covered or payable by the Plan if a claim for payment of such services is not submitted to the Claims Administrator within 12 months from the date that the service is rendered or the supply provided.
- Expenses for services related to **reading and learning disorders, dyslexia, educational delays, or vocational disabilities.**

COORDINATION OF BENEFITS

How Duplicate Coverage Occurs

This section describes the circumstances when you or your covered Dependents may be entitled to health care benefits under this Plan and may also be entitled to recover all or part of your health care expenses from some other source. In many of those cases, either this Plan or the other source of coverage (the primary plan or program) pays benefits or provides services first, and the other coverage (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits. This can occur if you or a covered Dependent is also covered by:

- Another group health care plan (including but not limited to a plan which provides the Covered Individual with COBRA Continuation Coverage);
- Medicare.
- Other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, motor vehicle insurance including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state or local government or agency.
- Workers' compensation.
- Coverage resulting from a judgment at law or settlement.
- Any responsible third party, its insurer, or any other source on behalf of that party.
- Any first party insurance (e.g. medical, personal injury, no-fault, underinsured motorist or uninsured motorist coverage).
- Any policy from any insurance company or guarantor of a third party
- Any other source (e.g. crime victim restitution, medical, disability, school insurance).

The Plan's benefit coverage is excess to other responsible parties' coverage sources such as coverage from a judgment, settlement, or any responsible party. Duplicate recovery of health care expenses can also occur if there is any other coverage for your health care expenses including third party liability.

In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your covered Dependent actually recover some or all of your losses from a third party (see also the subrogation provisions in this section). Duplicate recovery of health care expenses may also occur if a third party caused the injury or illness by negligent or intentionally wrongful action.

COVERAGE UNDER MORE THAN ONE GROUP HEALTH PLAN

When and How Coordination of Benefits (COB) Applies

Many families have family members covered by more than one medical or dental plan. If this is the case with your family, you must let this Plan and its Claims Administrators know about all

medical and dental] plan coverages when you submit a claim. Coordination of Benefits (or COB, as it is usually called) operates so that one of the Plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the health care expenses incurred. Sometimes, the combined benefits that are paid will be less than the total expenses.

WHICH PLAN PAYS FIRST: ORDER OF BENEFIT DETERMINATION RULES

The Overriding Rules

This Plan does not coordinate benefits with an individual plan, including a plan purchased through the Health Insurance Marketplace. Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.**

When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent or Dependent

1. The plan that covers a person other than a dependent, for example, as an employee, retiree, member or subscriber is the primary plan that pays first; and the Plan that covers the same person as a dependent is the secondary plan that pays second.
2. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (that is, the Plan covering the person as a retired employee); then the order of benefits is reversed, so that the Plan covering the person as a dependent pays first; and the Plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

1. The plan that covers the parent whose Birthday falls earlier in the calendar year pays first; and the Plan that covers the parent whose Birthday falls later in the calendar year pays second, if:
 - a. the parents are married;
 - b. the parents are not separated (whether or not they ever have been married); or
 - c. a court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.

2. If both parents have the same Birthday, the Plan that has covered one of the parents for a longer period of time pays first; and the Plan that has covered the other parent for the shorter period of time pays second.
3. The word “Birthday” refers only to the month and day in a calendar year; not the year in which the person was born.
4. If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the Plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s current Spouse does, the Plan of the Spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the Plan had actual knowledge of the specific terms of that court decree.

If the specific terms of a court decree state that both parents are responsible for the dependent child’s health care expenses or health care coverage, the Plan that covers the parent whose Birthday falls earlier in the calendar year pays first, and the Plan that covers the parent whose Birthday falls later in the calendar year pays second.

5. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the Plans of the parents and their Spouses (if any) is:
 - a. The plan of the custodial parent pays first; and
 - b. The plan of the Spouse of the custodial parent pays second; and
 - c. The plan of the non-custodial parent pays third; and
 - d. The plan of the Spouse of the non-custodial parent pays last.
6. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as described in Rule 5 (the longer/shorter length of coverage) and if length of coverage is the same, then the birthday rule (Rule 2) applies between the dependent child’s parents coverage and the dependent’s self or spouse coverage. For example, if a married dependent child on this Plan is also covered as a dependent on the group plan of their spouse, this Plan looks to Rule 5 first and if the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year: the employee-parent covering the dependent or the employee-spouse covering the dependent.

Rule 3: Active/Laid-Off or Retired Employee

1. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee’s dependent, pays first; and the Plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee’s dependent, pays second.

2. If the other plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
3. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

1. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the Plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the Plan providing continuation coverage to that same person pays second.
2. If the other plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
3. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

1. If none of the four previous rules determines the order of benefits, the Plan that covered the person for the longer period of time pays first; and the Plan that covered the person for the shorter period of time pays second.
2. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.
3. The start of a new plan does not include a change:
 - a. in the amount or scope of a plan's benefits;
 - b. in the entity that pays, provides or administers the Plan; or
 - c. from one type of plan to another (such as from a single employer plan to a multiple employer plan).
4. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the Plan presently in force.

Rule 6: When No Rule Determines the Primary Plan

If none of the previous rules determines which plan pays first, each plan will pay an equal share of the expenses incurred by the covered individual.

HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY:

Secondary Liability of this Plan: When this Plan pays second, it will pay, 100% of “Allowable Expenses” less whatever payments were actually made by the Plan (or plans) that paid first. It will reduce its benefits so that the total benefits paid or provided by all coordinating plans for each claim as it is processed is not more than 100% of total allowable expenses and in no case will this Plan pay more in benefits than it would have paid had it been the Plan that paid first.

“Allowable Expense” means a health care service or expense, including deductibles, coinsurance or copayments, which is covered in full or in part by any of the Plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the Plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- The difference between the cost of a semi-private room in a Hospital or Health Care Facility and a private room, unless the patient’s stay in a private Hospital room is determined (by the Plan Administrator or its designee) to be Medically Necessary.
- If the coordinating plans determine benefits on the basis of an Allowed charge amount, any amount in excess of the highest Allowed Charge is not an allowable expense.
- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- If one coordinating plan determines benefits on the basis of an Allowed charge amount and the other coordinating plan provides benefits or services on the basis of negotiated fees, the primary plan’s payment arrangement is the allowable expense for all plans.
- When benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan’s provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

Allowable expenses **do not include** expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

ADMINISTRATION OF COB

To administer COB, the Plan reserves the right to:

- a. exchange information with other plans involved in paying claims;
- b. require that you or your Health Care Provider furnish any necessary information;
- c. reimburse any plan that made payments this Plan should have made; or
- d. recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this

Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the Plan's Allowed charge.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

COORDINATION OF BENEFITS WITH MEDICARE

Entitlement to Medicare Coverage: Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage (usually after a waiting period).

Medicare Participants May Retain or Cancel Coverage Under This Plan: If an eligible individual under this Plan becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, that individual may either retain or cancel coverage under this Plan. If the eligible individual under this Plan is covered by both this Plan and by Medicare, as long as the eligible employee remains actively employed, that employee's medical expense coverage will continue to provide the same benefits and contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.

If an eligible individual under this Plan is covered by Medicare and an employee cancels coverage under this Plan, coverage of their Spouse and/or Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage if there has been a COBRA Qualifying Event. See the COBRA section for further information about COBRA Continuation Coverage. If any of the eligible employee's Dependents are covered by Medicare and the employee cancels that Dependent's coverage under this Plan (for instance the dependent is dropped from coverage at open enrollment time), that Dependent will **not** be entitled to COBRA Continuation Coverage, since being dropped at open enrollment is not a COBRA Qualifying Event.

The choice of retaining or canceling coverage under this Plan of a Medicare participant is the responsibility of the employee. Neither this Plan nor the employee's employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

Coverage Under Medicare and This Plan When Totally Disabled: If an eligible employee under this Plan becomes totally disabled and entitled to Medicare because of that disability, the eligible employee will no longer be considered to remain actively employed. As a result, once the employee becomes entitled to Medicare because of that disability, Medicare pays first and this Plan pays second. However, if an employee does remain actively employed or if an eligible dependent of an active employee covered under this Plan becomes totally disabled and entitled to Medicare because of that disability, this Plan pays first for that dependent and Medicare pays second.

Coverage Under Medicare and This Plan for End-Stage Renal Disease: If, while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

COORDINATION WITH GOVERNMENT AND OTHER PROGRAMS

1. **Medicaid:** If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second.
2. **TRICARE:** If a Dependent is covered by both this Plan and the TRICARE Program that provides health care services to Uniformed Service members, retirees and their families worldwide, this Plan pays first and TRICARE pays second. For an employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this Plan is secondary for active members of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by this Plan.
3. **Veterans Affairs/Military Medical Facility Services:** If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is **not** a military service-related illness or injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Allowed Charges.
4. **Motor Vehicle Coverage Required by Law:** If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second. The Plan's benefit coverage is excess to any vehicle insurance

(including medical payments coverage/MPC, personal injury protection/PIP, and/or no-fault).

5. **Indian Health Services (IHS):** If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.
6. **Other Coverage Provided by State or Federal Law:** If an eligible individual under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is 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.

WORKERS' COMPENSATION

This Plan **does not provide** benefits if the expenses are covered by workers' compensation or occupational disease law. If the individual's employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. Before such payment will be made, the individual must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee. However, the failure of the individual to sign such an agreement will not constitute a waiver by the Plan, the Plan Administrator, the Board of Trustees or the Claims Administrator of their rights to recover any payments that the Plan has advanced.

THIRD PARTY LIABILITY / SUBROGATION

Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party pays or is liable to pay due to any recovery, whether by settlement, judgment or otherwise. (See the exclusion regarding Expenses for Which a Third Party Is Responsible in the Exclusions section), but it will advance payment on account of Plan benefits (hereafter called an "Advance"), subject to its right to be reimbursed to the full extent of any Advance payment from the covered Employee and/or a representative, guardian, conservator, or trustee of the Covered Individual, and/or Dependent(s) if and when there is any recovery from any third party.

For this purpose, recovery includes without limitation any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from your uninsured or underinsured motorist, home owners or other insurance coverage related to the illness or injury, without reduction for any attorneys' fees paid or owed by you or on your behalf, and without regard to whether you or your dependent have been "made whole" by the recovery. Accordingly, the Plan does not recognize the "Make Whole Doctrine." A recovery also includes all monies received regardless of how held, and includes monies directly received by the Participant or eligible Dependent, as well as any monies held in any account or trust on their behalf, such as an attorney-client trust account.

Furthermore, if you and/or your Dependents are injured as a result of the negligence or other wrongful acts of a third party and you/your Dependents apply to the Plan for benefits and receive such benefits, the Plan shall then have a first-priority lien on any recovery for the full amount of the benefits that are paid to you and/or your dependents. In addition, in the event you and/or your dependents fail to seek to recover any monies from the third party that caused the injuries, the Plan

shall be subrogated to your right of recovery against that third party. You and your eligible dependents are responsible for all expenses incurred to obtain payment for third parties, including attorney fees, which amounts will not reduce the amount due to the Plan as restitution. Accordingly, the Plan expressly rejects the “Common Fund” doctrine with respect to the payment of attorney fees.

The right of reimbursement will apply:

- a) even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made; and
- b) even if the recovery is not sufficient to make the ill or injured employee and/or dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the “make-whole” rule); and
- c) without any reduction for legal or other expenses incurred by the employee and/or dependent(s) in connection with the recovery against the third party or that third party’s insurer pursuant to state law or otherwise (sometimes referred to as the “common fund” rule); and
- d) regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the “collateral source” rule); and
- e) even if the recovery was reduced due to the negligence of the covered Employee or covered Dependent (sometimes referred to as “contributory negligence”) or any other common law defense.

Reimbursement and/or Subrogation Agreement

The covered Employee **and/or** any covered Dependent(s) on whose behalf the Advance is made, must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the “**Agreement**”) in a form provided by or on behalf of the Plan. If the ill or injured Dependent(s) is a minor or incompetent to execute that Agreement, that person’s parent (in the case of a minor dependent child) or Spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Plan Administrator or its designee.

If the Agreement is not executed at the Plan Administrator’s request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan’s rights.

Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered Employee and/or covered Dependent(s) each agree:

- a) provide the Plan with a written notice of any claim made against a third party for damages as a result of an injury or illness; and
- b) to reimburse the Plan for all amounts paid or payable to the covered Employee and/or covered Dependent(s) or that third party’s insurer for the entire amount Advanced; and

- c) that the Plan has the first right of reimbursement from any judgment or settlement; and
- d) to do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights; and
- e) to not assign the right of recovery to any third party without the specific consent of the Plan; and
- f) to notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party alleged to be responsible for the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and
- g) to inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party; and
- h) ensure that any recovery is kept separate from and not co-mingled with any other funds and agree in writing that the portion of any recovery required to satisfy the lien of the Plan is held in trust for the sole benefit of the Plan until such time as it is conveyed to the Plan; and
- i) execute a lien in favor of the Plan for the full amount of the recovery which is due for benefits paid by the Plan; and
- j) periodically respond to information requests regarding the status of the claim against the third party, and notify the Plan, in writing, within ten (10) days after any recovery has been obtained; and
- k) direct any legal counsel retained by you or any other person acting on your behalf to hold that portion of the recovery to which the Fund is entitled in trust for the sole benefit of the Plan and to comply with and facilitate the reimbursement to the Fund of the monies owed to it (as described and defined below); and
- l) assign, upon the Plan's request, any right or cause of action to the Plan; and
- m) fully cooperate with the Plan Administrator in all respects in the Plan's enforcement of its equitable (or other) rights to restitution and keep the Plan informed of any important developments in your action; and
- n) not settle, without the prior written consent of the Plan Administrator, any claim that you or your eligible dependents may have against a third party, including an insurance carrier; and
- o) agree to the entry of judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the costs of such collection, including but not limited to the Fund's attorney fees and costs; and
- p) take all other action as may be necessary to protect the interests of the Plan.

If you or your Dependents fails to comply with any of the aforementioned requirements, no benefits will be paid with respect to the injury or illness. If benefits have already been paid, they may be recouped by the Plan.

Subrogation

By accepting an Advance, the covered Employee and/or covered Dependent(s) jointly agree that the Plan will be subrogated to the covered employee and/or covered dependent's right of recovery from a third party or that third party's insurer for the entire amount Advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that, in any legal action against a third party who may have been responsible for the injury or illness that resulted in the Advance, the Plan may be substituted in place of the covered Employee and/or covered Dependent(s), but only to the extent of the amount of the Advance. The Plan is subrogated in any and all actions against third parties for the portion of all recoveries that the Plan is entitled.

Under its subrogation rights, the Plan may, at its discretion:

- a) start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the covered Employee and/or covered Dependent(s), but in doing so, the Plan will **not** represent, or provide legal representation for the covered Employee and/or covered Dependent(s) with respect to their damages that exceed any Advance; or
- b) intervene in any claim, legal action, or administrative proceeding started by the covered Employee or covered Dependent(s) against any third party or third party's insurer concerning the injury or illness that resulted in the Advance.

Application to Any Fund

The Plan's right to reimbursement and subrogation shall apply to any fund, account or other asset created:

- a) pursuant to the judgment of any court awarding damages against any third party in favor of the ill or injured Employee and/or Dependent(s) payable by any third party on account of an illness or injury alleged to have been caused by that third party; or
- b) as a result of any settlement paid by any third party on account of any claim by or on behalf of the ill or injured Employee and/or Dependent(s).

Lien and Segregation of Recovery

By accepting the Advance the covered Employee and/or covered Dependent agrees to the following:

- a) The Plan will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment or otherwise, by the covered Employee and/or covered Dependent. The Plan's lien extends to any recovery from the third party, the third party's insurer, and the third party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health

insurance or other policy. The Plan's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.

- b) The Plan holds in a constructive trust that portion of the recovery that is the extent of the Advance. The covered Employee, covered Dependent, and those acting on their behalf, shall place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the Plan is satisfied. The location of the account and the account number must be provided to the Plan.
- c) Should the covered Employee, covered Dependent or those acting on their behalf, fail to maintain this segregated account or comply with any of the Plan's reimbursement requirements, they stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed.

Remedies Available to the Plan

In addition to the remedies discussed above, if the covered Employee or covered Dependent(s) does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

- a) apply any future Plan benefits that may become payable on behalf of the covered Employee and/or covered Dependent(s) to the amount not reimbursed; or
- b) obtain a judgment against the covered Employee and/or covered Dependent(s) for the amount Advanced and not reimbursed, and garnish or attach the wages or earnings of the covered Employee and/or covered Dependent(s).

By accepting an Advance or benefits from the Plan, you agree that the proceeds of any recovery paid to any other person or entity other than you, including but not limited to, a trust, an attorney or any agent thereof, shall be held by such other person, entity or trust in constructive trust for the Fund. You also agree that, except where mandated by statute, any lien the Plan may seek will not be reduced by any attorney fees, court costs or disbursements that you might incur in your action to recover from the third party, and these expenses may not be used to offset your obligation to reimburse the Plan for the full amount of the lien. Further, you agree that any recovery will not be reduced by and is not subject to the application of the "Common Fund" doctrine theory for the recovery of attorney fees.

Remember, the Plan does not require you to seek any recovery whatsoever against the third party, and if you do not receive any recovery from the party, you are not obligated in any way to reimburse the Plan for any of the benefits that you applied for and accepted. However, the Plan is entitled to obtain restitution of any amounts owed to it either from third-party funds received by you or your eligible dependents, regardless of whether you or your eligible dependents have been fully indemnified for losses sustained at the hands of the third party. Accordingly, in the event that you do not pursue any and all third parties and responsible sources, the Plan is authorized to pursue, sue, compromise or settle (at the Board of Trustees' discretion) any such claims on your behalf and you agree to execute any and all documents necessary to pursue said claims and, furthermore, to fully cooperate with the Plan in the prosecution of such claims. In accordance with this authority, a Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Plan's equitable (or other) right to obtain restitution. To this end, by participating in the Plan, you and your eligible dependents acknowledge

and agree to the terms of the Plan's equitable (or other) rights to full restitution. You and your eligible dependents also agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Plan Administrator, including the signing of any documents or agreements necessary for the Plan to obtain full restitution.

HOSPITALIZATION BENEFITS

The Plan provides Hospital benefits that are administered by Empire BlueCross BlueShield. This section describes those benefits.

Empire's Hospital Plan provides a broad range of benefits to you and your family. Following is a brief overview of the coverage. See the sections following this table for more details.

BENEFIT	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
EMERGENCY CARE		
EMERGENCY ROOM (Call within 48 hours of admission to certify hospital stay)	\$0 per visit copay	
EMERGENCY AIR AMBULANCE <ul style="list-style-type: none"> • Transportation to nearest acute care hospital for emergency inpatient admissions 	\$0	Covered in-network when specified criteria is met; subject to any applicable cost sharing. You may be required to pay the difference between the maximum allowed amount and the total charges of an out-of-network provider.
EMERGENCY LAND AMBULANCE <ul style="list-style-type: none"> • Local professional ground ambulance to nearest hospital 	\$0 up to the maximum allowed amount	Covered in-network, subject to meeting "emergency" criteria. When services are delivered by an out-of-network land ambulance provider that is not licensed under the NY Public Health Law, you may be required to pay up to the difference between the maximum allowed amount and the provider's total charges.*

* New York State law prohibits **land** ambulance providers in New York State from balance-billing beyond the maximum allowed amounts.

BENEFIT	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT HOSPITAL SERVICES		
DIAGNOSTIC PROCEDURES AND LAB TESTS <ul style="list-style-type: none"> • X-rays and other imaging • MRIs/MRAs All lab tests 	\$0	20% coinsurance
CHEMOTHERAPY AND RADIATION THERAPY	\$0	20% coinsurance
(including medications that are part of outpatient hospital treatment if prescribed by hospital pharmacy)	\$0	20% coinsurance
PRE-SURGICAL TESTING	\$0	20% coinsurance
AMBULATORY SURGERY		
KIDNEY DIALYSIS (including Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in the following settings until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare) <ul style="list-style-type: none"> • At home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered) • In a hospital-based facility • In a free-standing facility) 		
SAME DAY SERVICES		
(when performed in Outpatient Care Department – some procedures may require precertification)		
ANESTHESIA AND OXYGEN	\$0	20% coinsurance
BLOOD AND BLOOD DERIVATIVES FOR EMERGENCY CARE OR AMBULATORY SURGERY	\$0	20% coinsurance
BLOOD WORK FOR EMERGENCY CARE OR AMBULATORY SURGERY	\$0	20% coinsurance
SAME DAY AND HOSPITAL OUTPATIENT SURGICAL FACILITIES	\$0	20% coinsurance
WELL WOMAN CARE		
WELL-WOMAN CARE (available only in outpatient department of hospital) <ul style="list-style-type: none"> • Cervical cancer screenings (includes pelvic exam, in connection with evaluating pap smear) 	\$0	20% coinsurance
<ul style="list-style-type: none"> • Pap smears and diagnostic services • Mammogram (based on age and medical history) <ul style="list-style-type: none"> • – Ages 35 through 39 – 1 baseline • – Age 40 and older – 1 per year 	\$0	20% coinsurance
MATERNITY CARE		
ROUTINE NEWBORN NURSERY CARE (In hospital)	\$0	20% coinsurance

BENEFIT	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
OBSTETRICAL CARE (In hospital)	\$0	20% coinsurance
OBSTETRICAL CARE (In birthing center)	\$0	Not Covered
IN-PATIENT HOSPITAL SERVICES*1 (Pre-Certification Required)		
ANESTHESIA AND OXYGEN	\$0	20% coinsurance
BREAST CANCER SURGERY	\$0	20% coinsurance
CARDIAC CARE UNIT	\$0	20% coinsurance
CARDIAC REHABILITATION AND CARDIAC EQUIPMENT	\$0	20% coinsurance
CHEMOTHERAPY AND RADIATION THERAPY	\$0	20% coinsurance
DIAGNOSTIC X-RAYS AND LAB TESTS	\$0	20% coinsurance
DRUGS, DRESSINGS AND OTHER MEDICALLY NECESSARY SUPPLIES	\$0	20% coinsurance
GENERAL, SPECIAL AND CRITICAL NURSING CARE	\$0	20% coinsurance
INTENSIVE CARE	\$0	20% coinsurance
KIDNEY DIALYSIS	\$0	20% coinsurance
OPERATING AND RECOVERY ROOMS	\$0	20% coinsurance
SEMI-PRIVATE ROOM AND BOARD (when patient is under care of physician and Medically Necessary)	\$0	
SERVICES OF LICENSED PHYSICIAN OR SURGEON EMPLOYED BY HOSPITAL (if services included in hospital charges)	\$0	
SPECIAL DIET AND NUTRITIONAL SERVICES (while in hospital)	\$0	
SKILLED NURSING AND HOSPICE CARE		
SKILLED NURSING FACILITY • Up to 60 days per calendar year	\$0	Not covered
HOSPICE		Not covered

BENEFIT	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
<ul style="list-style-type: none"> Up to 210 days per lifetime 	\$0	
HOME HEALTH CARE		
HOME HEALTH CARE <ul style="list-style-type: none"> Up to 200 visits combined in- and out-of-network per calendar year (a visit equals 4 hours of care) 	\$0	20% Coinsurance only.
PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY (Precertification Required)		
PHYSICAL THERAPY AND REHABILITATION (in a hospital outpatient department or facility) <ul style="list-style-type: none"> Up to 30 days of inpatient service combined in- and out-of-network per calendar year 	\$0	20% coinsurance
<ul style="list-style-type: none"> Up to 30 outpatient visits combined in- and out-of-network per calendar year 	\$0	20% coinsurance
OCCUPATIONAL AND SPEECH THERAPY <ul style="list-style-type: none"> Up to 30 outpatient facility visits per person combined in- and out-of-network per calendar year 	\$0	20% coinsurance
MENTAL HEALTH CARE		
INPATIENT (Precertification required) <ul style="list-style-type: none"> Unlimited number of Medically Necessary days 	\$0	20% coinsurance
OTHER OUTPATIENT <ul style="list-style-type: none"> Unlimited number of Medically Necessary visits for the treatment of mental health care in a facility-based program 	\$0	20% coinsurance
CHEMICAL DEPENDENCE		
OTHER OUTPATIENT <ul style="list-style-type: none"> Unlimited number of Medically Necessary visits for treatment of mental health care in a facility-based program, including visits for family counseling 	\$0	20% coinsurance
INPATIENT (Precertification required) <ul style="list-style-type: none"> Unlimited number of Medically Necessary days of detoxification for chemical dependence Unlimited number of Medically Necessary rehabilitation days 	\$0 \$0	20% coinsurance 20% coinsurance

Please refer to the Health Management section for details regarding precertification requirements.

* Does not include inpatient physical, occupational, and speech therapy/rehabilitation. See the Coverage section for a description of these benefits

EMPIRE'S MEDICAL MANAGEMENT PROGRAM

Managing your health includes getting the information you need to make informed decisions, and making sure you get the maximum benefits the plan will pay. To help you manage your health, Empire provides the Empire's Medical Management Program, a service that precertifies hospital admissions and certain treatments and procedures, to help ensure that you receive the highest quality of care for the right length of time, in the right setting and with the maximum available coverage.

Empire's Medical Management Program works with you and your provider to help confirm the medical necessity of services and help you make sound health care decisions. The program helps ensure that you and your family members receive the highest quality of care at the right time, in the most appropriate setting.

You can contact our Medical Management program by calling the Member Services telephone number located on the back of your identification card.

How Empire's Medical Management Program Helps You

To help ensure that you receive the maximum coverage available to you, Empire's Medical Management Program

- Reviews all planned and emergency hospital admissions.
- Reviews ongoing hospitalization.
- Performs case management.
- Coordinates discharge planning.
- Reviews inpatient and ambulatory surgery.
- Reviews high-risk maternity admissions.
- Reviews care in a hospice or skilled nursing or other facility.

All other services will be subject to retrospective review by Empire's Medical Management team to determine medical necessity.

The health care services on the following page must be precertified with Empire's Medical Management Program.

CALL TO PRECERTIFY THE REQUIRED SERVICES...
FOR ALL HOSPITAL ADMISSIONS
<ul style="list-style-type: none">• At least two weeks prior to any planned surgery or hospital admission• Within 48 hours of an emergency hospital admission, or as soon as reasonably possible• Of newborns for illness or injury• Before you are admitted to a rehabilitation facility or a skilled nursing facility

MATERNITY CARE

- As soon as reasonably possible; we request notification within the first three months of pregnancy when possible (but is not required)
- Within 48 hours after the actual delivery date, if stay is expected to extend beyond the minimum length of stay for mother and newborn inpatient admission: forty-eight (48) hours for a vaginal birth; or ninety-six (96) hours for cesarean birth

BEFORE YOU RECEIVE/USE

- Inpatient Mental Health Care, Substance Abuse Care and Alcohol Detoxification
- Partial Hospital Programs, Psychological Testing, Intensive Outpatient Programs
- Occupational, Vision, Speech and Physical Therapy
- Outpatient/Ambulatory Surgical Treatment (certain procedures)
- Diagnostics
- Outpatient Treatments

If Services Are Not Precertified

If you call to precertify services as needed, you will receive maximum benefits. However, if you do not precertify and the admission or procedure is not Medically Necessary, your claim will be denied and no benefits will be paid.

Initial Decisions

Empire will comply with the following time frames in processing precertification, concurrent and retrospective review of requests for services.

- Precertification Requests. Precertification means that Empire's Medical Management Program must be contacted for approval before you receive certain health care services that are subject to precertification. Empire will review all non-urgent requests for precertification within three (3) business days of receipt of all necessary information but not to exceed 15 calendar days from the receipt of the request. If Empire does not have enough information to make a decision within 15 calendar days, a clinical denial of coverage is rendered. The letter you receive will tell you how to appeal to denial of coverage decision.
- Urgent Precertification Requests. If the need for the service is urgent, Empire will render a decision as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of our receipt of the request. If the request is urgent and Empire requires further information to make their decision, Empire will notify you within 24 hours of receipt of the request and you and your provider will have 48 hours to respond. Empire will make a decision within 48 hours of their receipt of the requested information, or if no response is received, within 48 hours after the deadline for a response.
- Concurrent Requests. Concurrent review means that Empire reviews your ongoing care during your treatment or hospital stay to be sure you get the right care in the right setting and for the right length of time. When the request to continue care is received at least 24

hours before the last approved day, Empire will complete all concurrent reviews of services within 24 hours of their receipt of the request.

- Retrospective Requests. Retrospective review is conducted after you receive medical services. Empire will complete all retrospective reviews of services already provided within 30 calendar days of their receipt of the claim. If Empire does not have enough information to make a decision within 30 calendar days, a clinical denial of coverage is rendered. The letter you receive will tell you how to appeal the denial of coverage decision. If Empire's Medical Management Program does not meet the above time frames, the failure should be considered a denial. You or your doctor may immediately appeal.

If Empire's Medical Management Program does not meet the above time frames, the failure should be considered a denial. If your claim is entirely or partially denied, you have the right to appeal such denial in accordance with the claims and appeal procedures set forth herein.

If A Request Is Denied

Approval or denial of certification of services will be provided to you, your doctor and the hospital, by telephone or in writing, within three business days once all necessary information is received. Before they notify you, your doctor or any other providers to discuss the treatment, the Medical Management Program will review all necessary medical records and information. If you or your provider disagrees with a Medical Management decision, you may request an appeal.

CASE MANAGEMENT

If You Need Additional Support for Serious Illness

The Medical Management Program's Case Management staff can provide assistance and support when you or a member of your family faces a chronic or catastrophic illness or injury. Staff nurses can help you and your family:

- Find appropriate, cost-effective health care options
- Reduce medical costs
- Help assure access to quality medical care
- A Case Manager serves as a single source for patient, provider, and insurer – helping to assure that the treatment, level of care, and facility are appropriate for your needs. For example, Case Management can help with cases such as:
 - Cancer
 - Stroke
 - AIDS
 - Chronic illness
 - Hemophilia
 - Spinal cord and other traumatic injuries

Assistance from Case Management is evaluated and provided on a case by case basis. In some situations, the Medical Management Program staff will initiate a review of a patient's health status

and the attending doctor's plan of care. They may determine that a level of benefits not necessarily provided by the Hospital Plan is desirable, appropriate and cost-effective. If you would like Case Management assistance following an illness or surgery, contact the Medical Management Program at 1-800-982-8089.

EMERGENCY CARE

Emergency Assistance 911

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of a hospital in Empire's network or the PPO network of another Blue Cross and/or Blue Shield plan. You pay only a copayment for a visit to an emergency room. This copayment is waived if you are admitted to the hospital within 24 hours. However, benefits for treatment in a hospital emergency room are limited to the initial visit for an emergency condition. You will need to show your Empire BlueCross BlueShield ID card when you arrive at the emergency room.

If You Need Emergency Care

Emergency care is covered in the hospital emergency room. To be covered as emergency care, the condition must be a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
2. Serious impairment to such person's bodily functions;
3. Serious dysfunction of any bodily organ or part of such person; or
4. Serious disfigurement of such person.

Emergency Services are defined as a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. With respect to an emergency medical condition, the term "Stabilize" means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility or to deliver a newborn child (including the placenta). Emergency Services are not subject to prior authorization requirements.

Sometimes you have a need for medical care that is not an emergency (i.e., bronchitis, high fever, sprained ankle), but can't wait for a regular appointment. If you need urgent care, call your physician or your physician's backup.

Please refer to the Health Management section for details regarding precertification requirements if you are admitted or need further care.

What's Not Covered

The following emergency services are not covered:

- Use of the Emergency Room:
 - To treat routine ailments
 - Because you have no regular physician or just because it is late at night
- Ambulette

MATERNITY CARE

The Plan also covers pregnancy and any pregnancy related treatment. It is important to notify the Plan as soon as you are aware that you are pregnant. Obstetrical and newborn care in the hospital or in a participating birthing center are covered up to 48 hours after a normal vaginal birth and 96 hours after a Cesarean section. Covered services are listed in “*Your Hospital Benefits At A Glance*”. Following are additional covered services and limitations:

- One home care visit if the mother leaves earlier than the 48 hour (or 96 hour) limit. The mother must request the visit from the hospital or a home health care agency within this time frame. The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later.
- Parent education, and assistance and training in breast or bottle feeding, if available
- Hospital services for circumcision of newborn males
- Special care for the baby if the baby stays in the hospital longer than the mother.
- Semi-private room
- Routine nursery care for well newborn is covered for up to 30 days during the mother's Medically Necessary confinement.

The following maternity care services are not covered:

- Services that are not Medically Necessary
- Private room
- Out-of-network birthing center facilities
- Private duty nursing

Please also refer to the rights under the *Newborns' and Mothers' Health Protection Act of 1996*, which are summarized herein on page 22.

HOSPITAL FACILITY (INCLUDING INPATIENT AND OUTPATIENT) SERVICES

The Plan also covers same-day (outpatient or ambulatory) hospital services, such as chemotherapy, radiation therapy, cardiac rehabilitation and kidney dialysis. Same-day surgical services or invasive diagnostic procedures are covered when they:

- Are performed in a same-day or hospital outpatient surgical facility,
- Require the use of both surgical operating and postoperative recovery rooms,

- May require either local or general anesthesia,
- Do not require inpatient hospital admission because it is not appropriate or Medically Necessary, and
- Would justify an inpatient hospital admission in the absence of a same-day surgery program.

Please refer to the Health Management Section for details regarding Precertification requirements.

Tips for Getting Hospital Care

If your doctor prescribes pre-surgical testing have your tests done within seven days prior to surgery at the hospital where surgery will be performed. For pre-surgical testing to be covered, you need to have a reservation for both a hospital bed and an operating room.

If you are having same-day surgery, often the hospital or outpatient facility requires that someone meet you after the surgery to take you home. Ask about their policy and make arrangements for transportation before you go in for surgery.

OUTPATIENT HOSPITAL CARE

Covered services are listed in Your Hospital Benefits At A Glance.

These outpatient services are not covered:

- Same-day surgery that requires the use of an outpatient department of a hospital or ambulatory facility not **precertified** as Medically Necessary by the Medical Management Program
- Routine medical care including but not limited to:
 - Inoculation or vaccination
 - Drug administration or injection, excluding chemotherapy
- Collection or storage of your own blood, blood products, semen or bone marrow

INPATIENT HOSPITAL CARE

Your Hospital Plan covers most or all of the cost of your Medically Necessary care when you stay at a network hospital for surgery or treatment of illness or injury.

Please refer to the Health Management Section for details regarding Precertification requirements.

These inpatient services are not covered:

- Private duty nursing
- Private room. If you use a private room, you need to pay the difference between the cost for the private room and the hospital's average charge for a semi-private room. The additional cost cannot be applied to your coinsurance.
- Diagnostic inpatient stays, unless connected with specific symptoms that if not treated immediately on an inpatient basis could result in serious bodily harm or risk to life

- Services performed in the following:
 - Nursing or convalescent homes
 - Institutions primarily for rest or for the aged
 - Rehabilitation facilities (except for physical therapy and for treatment of mental health and substance abuse disorders)
 - Spas
 - Sanitariums
 - Infirmarys at schools, colleges or camps
- Any part of a hospital stay that is primarily custodial or for a rest cure or convalescent or sanitarium type care or care that is not curative or restorative and is not a form of medical treatment. There are no benefits for care in a hospital, or in a separate division of a hospital, where half or more of the days of care provided by that hospital or that separate division of the hospital are during stays of more than 90 days in length
- Hospitalization or treatment of cosmetic surgery. However, cosmetic surgery shall not include reconstructive surgery when it is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part; or reconstructive surgery of the breast, when a mastectomy has been performed, including surgery and reconstruction of the other breast to produce a symmetrical appearance. For a covered child, benefits are available for cosmetic or reconstructive surgery for a functional defect which is caused by a congenital disease or anomaly.
- Hospital services received in clinic settings that do not meet Empire’s definition of a hospital or other covered facility. See “hospital/facility” in the Details and Definitions section.

SKILLED NURSING AND HOSPICE CARE

Benefits are only available at in-network facilities. Benefits are available in a facility that has a participating agreement with Empire or another Blue Cross or Blue Shield Plan or in a facility that is approved by the Joint Commission of Accreditation of Healthcare Organizations.

No Out-of-Network benefits are available.

You are covered for up to 60 inpatient days per calendar year in a network skilled nursing facility if you need medical care, nursing care or rehabilitation services when such care is, in our judgment, Medically Necessary and appropriate. Prior hospitalization is not required in order to be eligible for benefits. Services are covered if:

- The doctor provides:
 - A referral and written treatment plan,
 - A projected length of stay,
 - An explanation of the services the patient needs, and
 - The intended benefits of care.

- Care is under the direct supervision of a physician, registered nurse (RN), physical therapist, or other health care professional.

The following skilled nursing care services are not covered:

- Skilled nursing facility care that primarily:
 - Gives assistance with daily living activities
 - Is for rest or for the aged
 - Treats drug addiction or alcoholism
- Convalescent care
- Sanitarium-type care
- Rest cures

HOSPICE CARE

Empire's Hospital Plan covers up to 210 days of hospice care once in a covered person's lifetime. Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of six months or less. Hospice care can be provided in a hospice, in the hospice area of a participating hospital, or at home, as long as it is provided by a participating hospice agency. Hospice care is available in-network only.

Covered hospice care services, include:

- Up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN)
- Medical care given by the hospice doctor
- Drugs and medications prescribed by the patient's doctor that are not experimental and are approved for use by the most recent Physicians' Desk Reference
- Physical, occupational, speech and respiratory therapy when required for control of symptoms
- Laboratory tests, x-rays, chemotherapy and radiation therapy
- Social and counseling services for the patient's family, including bereavement counseling visits until one year after death
- Transportation between home and hospital or hospice when Medically Necessary
- Medical supplies and rental of durable medical equipment
- Up to 14 hours of respite care in any week

HOME HEALTH CARE

Home health care can be an alternative to an extended stay in a hospital or a stay in a skilled nursing facility. If you use an out-of-network agency, it must be certified by New York State or have comparable certification from another state. In –Network Empire participating home health

care agency cannot bill you for covered services. If you receive a bill from one of these providers, contact Member Services at 1-800-553-9603.

The following benefits are covered.

- Up to 200 home health care visits per calendar year, combined in- and out-of-network. A visit is defined as up to four hours of care. Your physician must certify home health care as Medically Necessary and approve a written treatment plan.
- Home health care services include:
 - Nursing care
Intermittent or part-time home nursing care. The care must be provided by or under the direct supervision of a registered nurse
 - Home health aids
Intermittent or part-time care provided by home health aides. Four hours of care equals one home care visit.
 - Rehabilitation care
Physical, speech or occupational therapy provided by the home health agency
 - Medical needs
Medical supplies, drugs and medications prescribed by a physician and laboratory services provided by or on behalf of a home health agency to the extent services would be covered if the covered member was in a hospital or a Skilled Nursing Facility as defined by Medicare.

The following home health care services are not covered:

- Custodial services, including bathing, feeding, changing or other services that do not require skilled care

PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY

Outpatient care must be given in an outpatient facility; inpatient therapy must be short-term.

- Occupational, speech or vision therapy, or any combination of these on an outpatient basis up to the plan maximums if:
 - Prescribed by a physician or in conjunction with a physician's services,
 - Given by skilled medical personnel in an outpatient facility,
 - Performed by a licensed speech/language pathologist or audiologist

The following therapy services are not covered:

- Therapy to maintain or prevent deterioration of the patient's current physical abilities

MENTAL HEALTH CARE

The following mental health care service are covered:

- Electroconvulsive therapy in the hospital or psychiatric facility for treatment of mental or behavioral disorder
- Care from psychiatrists, psychologists or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy and an additional three years of post-licensure supervised experience in psychotherapy.
- Outpatient mental health care
- Treatment in a New York State Health Department-designated Comprehensive Care Center for Eating Disorders pursuant to Article 27-J of the New York State Public Health Law.

Mental Health Parity Act of 2008 (“MHPA”)

MHPA generally requires that group health plans ensure that the financial requirements and treatment limitations for mental health and substance use benefits are no more restrictive than the requirements and limitations applied to the medical hospital and major medical coverage offered under the plan. Effective January 1, 2012, the Plan will apply the same standards for deductibles, copays, coinsurance and out-of-pocket expense maximums for mental health and substance use disorder benefits as it applies to medical and surgical benefits, in accordance with, and subject to the requirements of MHPA.

TREATMENT FOR CHEMICAL DEPENDENCY

Out-of-network outpatient treatment facility must:

- Has New York State pursuant to Article 32 of the New York State Mental Hygiene Law
- Is approved by the Joint Commission on the Accreditation of Health Care Organizations if out of state. The program must offer services appropriate to the patient’s diagnosis.

The following chemical dependence treatment services are not covered:

- Out-of-network outpatient chemical dependence treatment at a facility that does not meet certification requirements as stated above
- Care that is not Medically Necessary

EXCLUSIONS AND LIMITATIONS

Your Hospital Plan does not cover the following:

- *Dental Services*
Benefits will not be provided for dental care or treatment. However, Empire will provide covered benefits for services necessary due to an accidental injury to sound natural teeth rendered within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly is covered.
- *Experimental/Investigational Treatments*
Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA, Empire





will not cover any treatment, procedure, drug, biological product or medical device or any hospitalization in connection with such technology if, in Empire's discretion, it is determined that such technology is experimental or investigational.

- *“Experimental” or “investigative” means that the technology is:*
 - Not of proven benefit for the particular diagnosis or treatment of the covered participant's particular condition, or
 - Not generally recognized by the medical community as reflected in published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of the covered person's particular condition.
 - The Plan will also not cover any technology or any hospitalization in connection with such technology if, in Empire's discretion, such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of the covered person's particular condition.

Government approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a covered person's condition. Empire may apply the following five criteria in exercising the Plan's discretion and may in the Plan's discretion require that any or all of the criteria be met:

- Any medical device, drug or biological product must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the patient's particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, (e.g. investigational device exemption or an investigational new drug exclusion), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require any or all of the five criteria be met.
- Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.
- Demonstrated evidence as reflected in the published peer-review medical literature must exist that over time the technology leads to improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects).
- Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
- Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

- *Government Hospital Programs*
Services for benefits if the participant elects to receive Medicare or any other governmental program, except Medicaid
- *Government Hospital Services*
Government hospital services, except:
 - Specific services covered in a special agreement between Empire and a government hospital.
 - United States Veteran’s Administration or Department of Defense Hospitals, except services in connection with a service-related disability. In an emergency, Empire will provide benefits until the government hospital can safely transfer the patient to a participating hospital.
- *Home Care*
Services performed at home, except for those services specifically noted elsewhere in this Guide as available either at home or as an emergency.
- *Inappropriate Services*
 - Services or items or any portion of a stay in a hospital or facility covered under the plan, that in the Plan’s judgement, are not needed for proper medical care. If services or items or any portion of a stay are provided that cost more than other types of care, which in the Plan’s judgment, are equally or more beneficial, benefits may be limited to the cost of the less expensive type of care.
 - Services usually given without charge, even if charges are billed.
 - Services performed by hospital or institutional employees unless their services are included in the hospital charges and professional services of providers.
- *Medically Unnecessary Services*
Services, treatment or supplies not Medically Necessary in Empire’s judgment. See Definitions section for more information.
- *Miscellaneous*
Surgery and/or treatment for gender change
- *Prescription Drugs*
All prescription drugs and over the counter drugs, self-administered injectables, vitamins, appetite suppressants, oral contraceptives or any other type of medication, unless specifically indicated.
- *Services Provided Pursuant to a Prohibited Referral*
Services such as laboratory, radiation therapy, x-ray or imaging, and pharmacy services as required by New York State Public Health law from a facility in which the referring physician or his/her immediate family member has a financial interest or relationship.
- *Sterilization/Reproductive Technologies*
 - Reversal of sterilization
 - Assisted reproductive technologies including but not limited to:

-  In-vitro fertilization
 -  Artificial insemination
 -  Gamete and zygote intrafallopian tube transfer
 -  Intracytoplasmic sperm injection
- *Travel*
Travel, even if associated with treatment and recommended by a doctor
 - *War*
Services for illness or injury received as a result of war
 - *Workers' Compensation, No-Fault and Similar Legislation*
Workers' Compensation, the Federal Employers' Liability Act, the Longshoremen's and Harbor Workers' Compensation Act, Jones Act or similar law, and/or mandatory portion of a no-fault automobile insurance policy and similar legislation unless and until the covered person has exhausted all of the benefits available under these laws. This applies even if the covered participant does not claim benefits under the laws or policies of after any of the above benefits are paid, the covered participant must repay them because he or she recovers that money in a lawsuit or other proceedings.

Limitation as Independent Contractor

The relationship between Empire and hospitals, facilities or providers is that of independent contractors. Nothing in this contract shall be deemed to create between Empire and any hospital, facility or provider (or agent or employee thereof) the relationship of employer and employee or of principal and agent. Empire will not be liable in any lawsuit, claim or demand for damages incurred or injuries that you may sustain resulting from care received either in a hospital/facility or from a provider.

Claims

Empire's Hospital Plan makes health care easy by paying providers directly when you stay in-network. Therefore, when you receive care from providers or facilities in the Empire or BlueCard PPO networks, you generally do not have to file a claim because the provider files the claim directly with Empire or local Blue Cross/Blue Shield plan. However, you will have to file a claim for reimbursement for covered services received out-of-network, from a non-participating provider, or if you have a medical emergency out of the Empire service area. To obtain a claim form, call customer service. At some out-of-area and non-participating hospitals, you may have to pay the hospital's bill. If this happens, include an original itemized hospital bill with your claim.

Send completed forms to:

Hospital Claims	Empire BlueCross BlueShield P.O. Box 1407 Church Street Station New York, NY 10008-1407 Attention: Institutional Claims Department
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Tips for Filing a Claim

- File claims within 18 months of date of service.
- Visit www.empireblue.com to print out a claim form immediately or contact Member Services at 1-800-553-9603 to have one mailed to you.
- Complete all of the information requested on the claim form.
- Submit all claims in English or with an English translation.
- Attach original bills or receipts. Photocopies will not be accepted.
- If Empire is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill.
- Keep a copy of your claim form and all attachments for your records.

File claims within 18 months of the date of service to receive benefits.

If You Have Coverage Under Two Plans (Coordination of Benefits – COB)

Empire has a coordination of benefits (COB) feature that applies when you and members of your family are covered under more than one group health plan. The benefits provided by Empire will be coordinated with any benefits you are eligible to receive under the other group health plan on accordance with the applicable COB rules under the Plan.

Together, the plans will pay up to the amount of covered expenses, but not more than the amount of actual expenses.

When you are covered under two group health plans, one plan has primary responsibility to pay benefits and the other has secondary responsibility. The plan with primary responsibility pays benefits first.

If Empire is the Secondary Plan

If the Empire plan is secondary, then benefits will be reduced so the total benefits paid by both plans will not be greater than the allowable expenses. Also, Empire will not pay more than the amount Empire would normally pay if Empire were primary.

Tips for Coordinating Benefits

- To receive all the benefits available to you, file your claim under each plan.
- File claims first with the primary plan, then with the secondary plan.
- Include the original or a copy of the Explanation of Benefits (EOB) from the primary plan when you submit your bill to the secondary plan. Remember to keep a copy for your records.

If You Receive an Overpayment of Benefits

If you receive benefits that either should not have been paid, or are more than should have been paid, you must return any overpayment to Empire within 60 days of receiving it. Overpayments include:

- Payment for a service not covered by the Plan
- Payment for a person not covered the Plan
- Payment that exceeds the amount due under the Plan
- Duplicate payments for the same services

Health Care Fraud

Illegal activity adds to everyone's cost for health care. Empire welcomes your help in fighting fraud. If you know of any person who is receiving Empire BlueCross BlueShield benefits that they are not entitled to, call Empire. Empire will keep your identity confidential.

FRAUD HOTLINE

1-800-I.C.FRAUD (423-7283)

During normal business hours

If You Have Questions About a Benefit Payment

Empire reviews each claim for appropriate services and correct information before it is paid. Once a claim is processed, an Explanation of Benefits (EOB) will be sent directly to you if you have any responsibility on the claim other than your copayment amount or if an adjustment is performed on your claim.

If Empire reduces or denies a claim payment, you will receive a written notification or an Explanation of Benefits (EOB) citing the reasons your claim was reduced or denied.

The notification will give you:

- The specific reason(s) for the denial
- References to the pertinent plan provisions on which the denial is based
- A description of any additional material or information necessary for you to establish the claim and an explanation of why this material or information is necessary
- An explanation of claims review procedures including your right to appeal a claim decision for any reason other than a denial based on medical necessity or experimental or investigational.

If you have any questions about your claim, your Benefits Administrator may be able to help you answer them. You may also contact Empire Member Services at 1-800-553-9603 or in writing for more information. When you call, be sure to have your Empire ID card number handy, along with any information about your claim.

Under ERISA, if Empire denies a claim, wholly or partly, the Covered Person may appeal Empire's decision. The Covered Person will be given written notice of why the claim was denied, and of his right to appeal the decision. Then the Covered Person has 180 days to appeal Empire's decision. The Covered Person (or his authorized representative) may submit a written request for review. The Covered Person may ask for a review of pertinent documents, and the Covered Person may also submit a written statement of issues and comments. The claim will be reviewed and Empire will make a decision within sixty (60) days after the appeal is received. If special

circumstances require an extension of time, the extension will not exceed 120 days after the appeal is received. The decision will be in writing, containing specific reasons for the decision.

REIMBURSEMENT FOR COVERED SERVICES

Maximum Allowed Amount

This section describes how Empire determines the amount of reimbursement for Covered Services. Providers who have entered into an agreement with Empire to participate in their provider network or who have agreed to render services to covered persons under Your Plan are referred to in this Rider as Participating Providers. Providers who have not signed any contract with Empire and are not in any of Empire's networks are referred to as Nonparticipating Providers.

Reimbursement for services rendered by Participating and Nonparticipating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the Blue Cross and Blue Shield Association BlueCard Program section/Rider for additional information regarding services received outside of Empire's service area.

The Maximum Allowed Amount is the maximum amount of reimbursement Empire will pay for services and supplies:

- that meet the definition of services and supplies that are covered under Your Plan and are not excluded ("Covered Services");
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, Medical Management Programs or other requirements set forth in Your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met any applicable Deductible, Copayment or Coinsurance. In addition, when you receive Covered Services from a Nonparticipating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, Empire will, to the extent applicable, apply claim processing and reimbursement rules to the claim submitted for those Covered Services. These rules evaluate the claim information and determine, among other things, the appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means Empire has determined that the claim submitted was inconsistent with the procedure coding rules and/or their reimbursement policies.

For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Provider or other healthcare professional, Empire may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Nonparticipating Provider.

For Covered Services performed by a Participating Provider, the Maximum Allowed Amount is the rate the Provider has agreed with Empire to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for that service, they are prohibited by contract from sending you a bill, or otherwise attempting to collect amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent that you have not met your Deductible, or have a Copayment, Coinsurance, or other form of cost share under the terms of Your Plan. Please call Customer Service for help in finding a Participating Provider or visit www.empireblue.com.

For Covered Services that you receive from a Nonparticipating Provider, the Maximum Allowed Amount will be based on Empire's Nonparticipating Provider fee schedule/rate or the Provider's charge, whichever is less. Empire's Out-of-Network Provider fee schedule/rate may be accessed by calling the Customer Service number on the back of your identification card. The Maximum Allowed Amount on your Nonparticipating fee schedule/rate has been developed by reference to one or more of several sources, including the following:

1. Amounts based on Empire's Participating Provider fee schedule/rate;
2. Amounts based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services, unadjusted for geographic locality, for the same services or supplies. Such reimbursement amounts will be updated no less than annually;
3. Amounts based on charge, cost reimbursement or utilization data;
4. Amounts based on charge, cost reimbursement or utilization data;
5. Amounts based on information provided by a third party vendor, which may reflect one or more of the following factors: i) the complexity or severity of treatment; ii) level of skill and experience required for the treatment; or iii) comparable Providers' fees and costs to deliver care; or

An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management. Providers who are not contracted for this Plan, but contracted for other Plans with Empire, are also considered Nonparticipating. The Maximum Allowed Amount reimbursement for services from these Providers will be based on Empire's Nonparticipating Provider fee schedule/rate as described above unless the contract between Empire and that Provider specifies a different amount.

Unlike Participating Providers, Nonparticipating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Empire's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding Participating Providers or visit Empire's website at www.empireblue.com.

Customer Service is also available to assist you in determining the Maximum Allowed Amount for a particular service from a Nonparticipating Provider. In order for Empire to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

Member Cost Share

For certain Covered Services and depending on Your Plan, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment and/or Coinsurance).

Your cost share amount and annual out-of-pocket limit may vary depending on whether you received services from a Participating or a Nonparticipating Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Nonparticipating Providers. Please see the terms of this Certificate and the Schedule of Benefits for your cost share amounts and limitations, or call Customer Service to learn how Your Plan's benefits or cost share amounts may vary by the type of Provider you use.

Empire will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services regardless of whether such services are performed by a Participating Provider or a Nonparticipating Provider. Both services specifically excluded by the terms of Your Plan and those received after benefits have been exhausted are non-Covered Services. Benefits may be exhausted by exceeding, for example, your lifetime maximum, benefit caps, or day/visit limits. Note that no coverage is available for services provided by Nonparticipating Providers if Your Plan requires the services to be provided only by Participating Providers.

In some instances you may only be asked to pay the lower cost sharing amount that applies to Participating Provider services when you use a Nonparticipating Provider. For example, if you go to a Participating Provider Hospital or Facility and receive Covered Services from a Nonparticipating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or Facility, to the extent you have coverage for those services, you will pay the cost share amounts that apply to Participating Providers for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Nonparticipating Provider's charge.

Authorized Services

In some circumstances, such as where there is no Participating Provider available for the Covered Service, Empire may authorize the cost share amounts that apply to Participating Provider services (such as Deductible, Copayment and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Nonparticipating Provider. In such circumstance, you must contact Empire in advance of obtaining the Covered Service. Empire will also authorize the cost share amounts that apply to Participating Provider services if you receive Emergency services from a Nonparticipating Provider. If Empire authorizes Covered Services from a Nonparticipating Provider so that you are responsible for the In-Network cost share amounts, you may still be liable for the difference between the Maximum Allowed Amount and the Nonparticipating Provider's charge. Please contact Customer Service for information or to request authorization.

COMPLAINTS, APPEALS AND GRIEVANCES

An appeal is a request to review and change an adverse determination made when (i) Empire's Medical Management Program (MMP) or Mental and Behavioral Health Care Manager (MBHCM) determines a service is not Medically Necessary, or is excluded from coverage because it is considered Experimental or Investigational; or (ii) if Empire denies a claim, wholly or partly, for services already rendered based on their utilization review process.

In the event that Empire renders an adverse determination without attempting to discuss such matter with the Covered Person's health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination. Except in cases of retrospective reviews, such reconsideration shall occur within one (1) business day of receipt of the request and shall be conducted by the Covered Person's health care provider and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer cannot be available. In the event that the adverse determination is upheld after reconsideration, Empire shall provide notice as required pursuant to subsection 3 of this Section. Nothing in this Section shall preclude the Covered Person from initiating an appeal from an adverse determination.

Standard Level 1 Appeals

The Covered Person (or the Covered Person's authorized representative, or health care provider) may file a formal appeal by telephone or in writing. An appeal must be filed within one hundred eighty (180) calendar days from the date of receipt of notice of a denial of services. An appeal submitted beyond the one hundred eighty (180) day filing limit will not be accepted for review.

Empire will send written notice of acknowledgement of the appeal within fifteen (15) days of receipt of that appeal to the Covered Person or the Covered Person's authorized representative. The appeal will be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination. A final determination will be made within the following time frames after receiving all necessary information or medical records related to the appeal request.

- *Precertification.* Empire will complete their review of a precertification appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.

- *Concurrent.* Empire will complete their review of a concurrent appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.
- *Retrospective.* Empire will complete their review of a retrospective appeal within 30 calendar days of receipt of the appeal.

Empire will provide a written notice of their determination to the Covered Person’s representative, and Provider within two (2) business days of reaching a decision. The decision will include the reason(s) for the determination, including the clinical rationale if the adverse determination is upheld, date of service, claim amount (if applicable), diagnosis code and treatment code, and corresponding meaning of these codes. The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will also specify what, if any, additional necessary information must be provided to or obtained by Empire in order to render a decision on appeal and an explanation of why the information is necessary. The notice will also advise you of your right to appeal Empire’s determination, give instructions for requesting a standard or expedited internal appeal and initiating an external appeal.

If Empire does not make a decision within sixty (60) calendar days of receiving all necessary information to review your appeal, Empire will approve the service.

The claim will be reviewed and Empire will make a decision within sixty (60) days after the appeal is received. If special circumstance require an extension of time, the extension will not exceed one hundred twenty (120) days after the appeal is received. The decision will be in writing, containing specific reasons for the decision.

Expedited Level 1 Appeals

Empire will speed up the appeal process (an “expedited appeal”) and deliver a rapid decision when the situation involves:

- i. Continuations or extensions of health care services, procedures or treatments already begun;
- ii. Additional required or provided care during an ongoing course of treatment; or
- iii. A case in which the Provider believes an immediate appeal is warranted, or
- iv. When home health care is requested following discharge from an inpatient hospital admission.

When requested under these circumstances, the following time frames will apply:

- Empire will provide the Covered Person or his Provider with reasonable access to our clinical reviewer within one (1) business day of receiving a request for an expedited appeal. The Provider and clinical peer reviewer may exchange information by telephone or fax.
- Empire will make a decision on an expedited appeal within the lesser of seventy-two (72) hours of receipt of the appeal request or two (2) business days following receipt of all necessary information about the case, but in any event within seventy-two (72) hours of receipt of the appeal.
- Empire will notify the Covered Person and his Provider immediately of the decision by telephone and will transmit a copy of the decision in writing within twenty-four (24) hours after the decision is made.

- If the Covered Person is not satisfied with the resolution of the expedited appeal, a further appeal may be made through the standard appeal process, as described in this subsection.
- If Empire does not make a decision within two (2) business days of receiving all necessary information to review the Covered Person's appeal, Empire will approve the service.

Standard Level 2 Appeals

If the Covered Person is dissatisfied with the outcome of the Level 1 Appeal, a Level 2 Appeal may be filed with Empire within sixty (60) business days from the receipt of the notice of the letter denying the Level 1 Appeal. If the appeal is not submitted within that timeframe, Empire will not review it and their decision on the Level 1 appeal will stand. Appeals may be filed by telephone or in writing.

Empire will make a decision within the following timeframes for Level 2 Appeals:

- Precertification. Empire will complete their review of a precertification appeal within 15 calendar days of receipt of the appeal.
- Concurrent. Empire will complete their review of a concurrent appeal within 15 calendar days of receipt of the appeal.
- Retrospective. Empire will complete their review of a retrospective appeal within 30 calendar days of receipt of the appeal.

How To Request An Appeal

To submit an appeal, call Member Services at the telephone number located on the back of your identification card, or write to the applicable address(es) listed below. Please submit any data to support your request and include your member identification number and if applicable, claim number and date of service.

Empire Appeal and Grievance Department
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Send appeals concerning behavioral health care to:

Grievances and Appeals – Behavioral Health
P.O. Box 2100
North Haven, CT 06473

Complaints

A complaint is a verbal or written statement of dissatisfaction where Empire is not being asked to review and overturn a previous determination. For example: You feel you waited too long for an answer to your letter to Empire. If you have a complaint about any of the healthcare services your Plan offers, plan procedures or our customer service, call Member Services. Member Services may ask you to put your complaint in writing if it is too complex to handle over the telephone.

Empire Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Send appeals concerning behavioral health care to:

Grievances and Appeals – Behavioral Health
P.O. Box 2100
North Haven, CT 06473

Empire will resolve complaints within the following timeframes:

- *Standard complaints.* Within 30 days of receiving all necessary information.
- *Expedited complaints.* Within 72 hours of receiving all necessary information.

Level 1 Grievance

A grievance is a verbal or written request for a review of an adverse determination concerning an administrative decision not related to medical necessity.

A Level 1 Grievance is your first request for review of Empire's administrative decision. You have one hundred eighty (180) calendar days from the receipt of the notification letter to file a grievance. A grievance submitted beyond the one hundred eighty (180) calendar day limit will not be accepted for review.

If these services have already been provided, Empire will acknowledge your grievance in writing within fifteen (15) calendar days from the date Empire received your grievance. The written acknowledgement will include the name, address, and telephone number of the department that will respond to the grievance, and description of any additional information required to complete the review.

Empire will make a decision within the following timeframes for 1st Level Grievances:

- *Pre-service (services have not yet been rendered).* Empire will complete their review of a pre-service grievance (other than an expedited grievance) within fifteen (15) calendar days of receipt of the grievance.
- *Post-service (services have already been rendered).* Empire will complete their review of a post-service grievance within thirty (30) calendar days of receipt of the grievance.

Level 2 Grievances

If you are dissatisfied with the outcome of your Level 1 Grievance, you may file a Level 2 Grievance with Empire. Empire must receive your request for a Level 2 Grievance by the end of the sixtieth (60th) business day after you receive our notice of determination on your Level 1 Grievance. If the Level 2 Grievance is not submitted within that timeframe, Empire will not review it and the decision on the Level 1 Grievance will stand. Empire will acknowledge receipt of the 2nd Level Grievance within fifteen (15) days of receiving the grievance. The written acknowledgement will include the name, address and telephone numbers of the department that will respond to the grievance. A qualified representative (including clinical personnel, where

appropriate) who did not participate in the Level 1 Grievance decision will review the Level 2 Grievance.

Empire will make a decision within the following timeframes for 2nd Level Grievances:

- *Pre-service.* Empire will complete their review of a pre-service grievance within fifteen (15) calendar days of receipt of the grievance.
- *Post-service.* Empire will complete their review of a post-service grievance within thirty (30) calendar days of receipt of the grievance.

Expedited Grievances

You can file an expedited Level 1 or Level 2 Grievance and receive a quicker response if a delay in resolution of the grievance would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Expedited Grievances may be filed by telephone and in writing. When you file an expedited grievance, Empire will respond as soon as possible considering the medical circumstances of the case, subject to the following maximum timeframes:

- Empire will make a decision within 48 hours of receipt of all necessary information, but in any event within seventy-two (72) hours of receipt of the grievance.
- Empire will notify you immediately of the decision by telephone, and within two (2) business days in writing.

Decision On Grievances

Empire's notice of its Grievance decision (whether standard or urgent) will include:

- The reason for Empire's decision, or a written statement that insufficient information was presented or available to reach a determination,
- The clinical rationale, if appropriate, and
- For Level 1 Grievances, instructions on how to file a Level 2 Grievance if you are not satisfied with the decision.

How To File A Grievance

To submit an appeal or grievance, call Member Services at the telephone number located on the back of your ID card, or write to the following address with the reason why you believe Empire's decision was wrong. Please submit any data to support your request and include your member ID number and, if applicable, claim number and date of service.

Empire Appeal and Grievance Department
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Send appeals concerning behavioral healthcare to:

Grievances and Appeals – Behavioral Health
P.O. Box 2100
North Haven, CT 06473

How You Can Participate In Policy Development

Empire welcomes your input on policies that they have developed or you would like them to initiate. If you wish to share any ideas with Empire, they encourage you to write to them at:

Empire Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Empire will forward your ideas to the department responsible for developing the type of policy involved, and your suggestions will be reviewed and considered. You will then receive a response to your comments. In addition, Empire reviews member complaints, member satisfaction information, new technology, and new procedures to determine if charges should be made to your benefits.

Provider Quality Assurance

Because your health care is so important, Empire has a Quality Assurance Program designed to ensure that their network providers meet their high standards for care. Through this program, Empire continually evaluates the network providers.

If you have a complaint about a network provider's procedures or treatment decisions, share your concerns directly with your provider. If you are still not satisfied, you can submit a complaint at the above address. Empire will refer complaints about the clinical quality of the care you receive to the appropriate clinical staff member to investigate.

Empire also encourages you to send suggestions to Member Services for improving their policies and procedures. If you have any recommendations on improving their policies and procedures, please send them to the Member Services address above.

HOSPITAL/FACILITY

A fully licensed acute-care general facility that has all of the following on its own premises:

- A broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies
- 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times
- A fully-staffed operating room suitable for major surgery, together with anesthesia service and equipment. The hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care

- Assigned emergency personnel and a “crash cart” to treat cardiac arrest and other medical emergencies
- Diagnostic radiology facilities
- A pathology laboratory
- An organized medical staff of licensed doctors

For pregnancy and childbirth services, the definition of “hospital” includes any birthing center that has a participation agreement with either Empire BlueCross BlueShield, or another Blue Cross and/or Blue Shield plan.

For physical therapy purposes, the definition of a “hospital” may include a rehabilitation facility either approved by Empire BlueCross BlueShield, or participating with Empire or another Blue Cross and/or Blue Shield plan other than specified above.

For kidney dialysis treatment, a facility in New York State qualifies for in-network benefits if the facility has an operating certificate issued by the New York State Department of Health, and participates with Empire or another Blue Cross and/or Blue Shield plan. In other states, the facility must participate with another Blue Cross and/or Blue Shield plan and be certified by the state using criteria similar to New York’s. Out-of-network benefits will be paid only for non-participating facilities that have an appropriate operating certificate.

For behavioral health care purposes, the definition of “hospital” may include a facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; or a facility that has a participation agreement with Empire to provide mental and behavioral health care services. For chemical dependence treatment received out-of-network, a facility in New York State must be certified by the Office of Alcoholism and Substance Abuse Services. A facility outside of New York State must be approved by the Joint Commission on the Accreditation of Healthcare Organizations.

For certain specified benefits, the definition of a “hospital” or “facility” may include a hospital, hospital department or facility that has a special agreement with Empire BlueCross BlueShield

Empire’s Hospital Plan does not recognize the following facilities as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted above); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps; and any institution primarily for the treatment of drug addiction, alcoholism or mental health care.

In-Network Provider/Supplier

A hospital, facility or home health care agency who:

- Is in Empire’s Hospital network
- Is in the PPO network of another Blue Cross and/or Blue Shield plan
- Has a negotiated rate arrangement with another Blue Cross and/or Blue Shield plan that does not have a PPO network

Itemized Bill

A bill from a hospital or ambulance service, which gives information that Empire needs to settle your claim. Hospital bills will contain the patient's name, diagnosis, and date and charge for each service performed. A hospital bill will have the subscriber's name and address, the patient's date of birth and the plan holder's Empire identification number.

Maximum Allowed Amount (MAA)

The maximum dollar amount of reimbursement for Covered Services. Please see the Maximum Allowed Amount Reimbursement for Covered Services section for additional information.

Medically Necessary

As used in this plan services will be deemed Medically Necessary only if, they are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for illness, injury, or disease; they are required for the direct care and treatment or management of that condition; your condition would be adversely affected if the services were not provided; they are provided in accordance with generally-accepted standards of medical practice; they are not primarily for the convenience of You, Your family, or Your Provider; they are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results; when setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, there will be no coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or in the home setting.

Non-Participating Hospital/Facility

A hospital or facility that does not have a participation agreement with Empire BlueCross BlueShield, or another Blue Cross and/or Blue Shield plan to provide services to persons covered under the Empire Hospital contract. Or, a hospital or facility that does not accept negotiated rate arrangements as payment in full in a plan area without a PPO network.

Operating Area

Empire BlueCross BlueShield operates in the following 28 eastern New York State counties: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester.

Out-Of-Network Benefits

Reimbursement for covered services provided by out-of-network hospital and facilities.

Out-Of-Network Providers/Suppliers

A hospital, facility or home health care agency who:

- Is not in Empire's network

- Is not in the PPO network of another Blue Cross and/or Blue Shield plan
- Does not have a negotiated rate with another Blue Cross and/or Blue Shield plan

Outpatient Surgery

See “same-day surgery.”

Plan Administrator

The person who has certain authority concerning the health plans, such as plan management, including deciding questions of eligibility for participation, and/or the administration of plan assets. Empire is not the Plan Administrator. To identify your Plan Administrator, contact your employer or health plan sponsor.

Precertified Services

Services that must be coordinated and approved by the Medical Management Program to be fully covered by your plan. For example, planned inpatient surgery, MRIs and MRAs. Failure to precertify, may result in a reduction or denial of benefits.

Provider

A “hospital/facility or home health care agency or skilled nursing facility.

Same-Day Surgery

Same-day, ambulatory or outpatient surgery is surgery that does not require an overnight stay in a hospital.

Treatment Maximums

Maximum number of treatments or visits for certain conditions. Maximums for in-network and out-of-network services are combined. For example, if the plan has a limit of 30 visits on a covered expense, you would reach the limit if you had 17 visits in-network and 13 visits out-of-network.

CLAIMS AND APPEALS PROCEDURES FOR MEDICAL CLAIMS

This section describes the procedures followed by the Plan in making internal claims decisions and reviewing appeals of denied claims. These procedures described in this section apply to claims for medical, dental, vision, and prescription drug benefits as well as hospital benefits. However, procedures that apply to Empire Blue Cross Blue Shield Hospitalization benefits are described in more detail in the Hospitalization Benefits section of this document. The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants and dependents. In addition, the Plan may consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational).

HOW TO RECEIVE BENEFITS UNDER THE PLAN (THE PLAN'S REASONABLE CLAIMS PROCEDURES)

All claims are considered for payment when they are received by the organization responsible for administering the benefits as described below. The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

DEFINITION OF A CLAIM

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

Types of Claims

Health Benefit Claims

Health benefit claims can be filed for medical, dental, vision, and prescription drug benefits.

There are four categories of health claims as described below:

Pre-Service Claims - A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained.

- ***Urgent Care Claims*** – An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.

- **Concurrent Claims** - A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

Under this Plan, there are no penalties for failure to pre-authorization benefits under the Plan. Empire does maintain Medical Management procedures for Hospital claims and follows the timing requirements for pre-service claims. While there is no penalty if you do not precertify the admission or procedure, if it is not Medically Necessary, your claim will be denied and no benefits will be provided. See the Hospital section for Empire's procedures under its Medical Management Program and timing of pre-service claims. The only claims under the benefits discussed in this Section under this Plan are Post-Service claims.

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

Death Benefit Claims

A Death Benefit Claim is a request by a designated beneficiary for benefit payment following the death of the participant.

Claim Elements

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

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

A request is not a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);

- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan;
- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision provider(s). After the denial by the vision service provider, you may file a claim with the Plan.

If you submit a claim that is not complete or lacks required supporting documents, the Plan Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This notification may be oral, unless you (or your representative) request a written notice. Unless the claim is refiled properly, it will not constitute a claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

Adverse Benefit Determination

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

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;
- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational.

CLAIMS ADMINISTRATORS

The Board of Trustees has delegated responsibility for initial claims decision as follows.

Hospital Claims

See the Hospital section for information on how to file claims for Empire hospital benefits.

Medical, Out-of-Network Optical, and Death Benefit Claims

When you need to file a claim for benefits for Medical, Optical, and Death benefit claims, as described on the next two pages, submit these claims to the Fund Office. These claims must be filed within 12 months following the date the charges were incurred.

Please note that all services are subject to the requirement that they are "Medically Necessary", as defined by the Plan. If you wish to receive a determination of medical necessity prior to receiving care, please contact the Fund Office. However, no claims require that this determination be made.

Medical Claims

In network providers will bill the Plan directly. There are no claim forms for you to file. If there is any balance due the provider, you will be billed directly by the provider after the bill has been processed by MagnaCare and the Plan. You must submit a claim for out-of-network providers to the Fund Office.

Optical Claims

There are no claims to submit if you use a Vision Screening or General Vision Services (GVS) providers.

If you use an out-of-network provider, you must obtain a direct reimbursement form from the Fund Office. You pay the provider directly for all charges. You will be reimbursed up to the scheduled limit. To obtain the reimbursement, have your provider fill out the applicable sections and submit the completed form to the Fund Office.

Death Benefit

In order to file a claim for the Death benefit offered under this Plan, you or your beneficiary must contact the Fund Office to determine what documentation is required to file a claim for benefits.

Dental Claims

If you use a SIDS panel Dentist, there are no claims to file. When you use a non-panel dentist, you need to file a claim form. Completed claim forms, with x-rays and other attachments, should be sent to:

Self-Insured Dental Services
Dept. 75
PO Box 9005
Lynbrook, NY 11563-9005
(516) 396-5500 or (718) 204-7172

Non-participating providers cannot be reimbursed directly. You are responsible for paying the dentist and reimbursement will be made to you.

Prescription Drug Benefits

You do not need claim forms when visiting a SaveRx pharmacy. Simply present your card and your prescription to the pharmacist. When you present a prescription to a pharmacy to be filled under the terms of this plan, that request is not considered a claim under these procedures. However, if your request for a prescription is denied in whole or in part, you may file a claim under these procedures. If you need to file a claim contact the Fund Office for a claim form. Claims should be submitted to SaveRx at:

SaveRx
224 North Park Avenue
Fremont, Nebraska 68025
(800) 228-3108

AUTHORIZED REPRESENTATIVES

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Claim (defined below) without you having to complete the special authorization form.

HEALTH CARE CLAIMS – DECISION TIMEFRAMES

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

PRE-SERVICE, URGENT CARE AND CONCURRENT CLAIMS

A Pre-Service Claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Currently, there are no pre-authorization requirements for Medical, Prescription Drug, Dental or Optical benefits under Plan. See the Hospital section for Empire's procedures under its Medical Management Program.

POST-SERVICE CLAIM (applicable to medical, prescription drug, dental, optical, and hospital claims)

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

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

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

earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

Death Benefit – Decision Timeframe

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

Disability Claims

A Disability Claim is any claim for a benefit where the availability of the benefit is conditioned on a finding by the Plan of disability.

For Disability Claims, the Plan will make a decision on the claim and notify you of the decision within 45 days. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional 30 days, provided the you are notified prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Plan's request for the information, you will be notified of the Plan's decision on the claim within 30 days.

NOTICE OF ADVERSE BENEFIT DETERMINATION

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

- Identify the claim involved (e.g., date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (including a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however such a request is not considered to be a request for an internal appeal;

- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- Provide an explanation of the Plan's internal appeal process along with time limits and information about how to initiate an appeal;
- Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;
- If the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that such rule, guideline, protocol or similar criteria that was relied upon will be provided to you free-of-charge upon request;
- If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request; and
- For Urgent Care Claims, the notice Empire will provide will describe the expedited internal appeal process applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification.

REQUEST FOR REVIEW OF DENIED CLAIM

If an initial health care claim is denied (in whole or in part) and you disagree with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period. Accordingly, if you fail to request review of the denial of your claim within this 180-day period, you will lose the right to obtain a review of the original decision denying your claim and that decision will be final and binding upon you (and your eligible dependents, if applicable). This failure will not, however, prevent you from establishing benefit entitlement at a later date based on additional information and evidence which was not available at the time of the decision denying the claim.

Your request for review must be made in writing to the applicable organization as noted below:

- **Empire Hospital Appeals including Pre-Service (including Urgent Care and Concurrent) and Post-Service Appeals**

See the Empire section for details on how Empire handles appeals under its medical management program. In general, Empire maintains a two-level appeal procedure. Empire breaks appeals into two categories, Appeals and Grievances, which they define as follows:

- An appeal is a request to review and change an adverse determination made when (i) Empire's Medical Management Program (MMP) or Mental and Behavioral Health Care Manager (MBHCM) determines a service is not Medically Necessary, or is excluded from coverage because it is considered Experimental or Investigational; or (ii) if Empire denies a claim, wholly or partly, for services already rendered, based on their utilization review process.
- A grievance is a verbal or written request for a review of an adverse determination concerning an administrative decision not related to medical necessity.

To submit an appeal or grievance, call Member Services at the telephone number located on the back of your identification card, or write to the applicable address(es) listed below. Please submit any data to support your request and include your member identification number and if applicable, claim number and date of service.

Empire Appeal and Grievance Department
 PO Box 1407
 Church Street Station
 New York, NY 10008-1407

Send appeals concerning behavioral health care to:

Grievances and Appeals – Behavioral Health
 P.O. Box 2100
 North Haven, CT 06473

Urgent Care appeals may be made orally or in writing. See the Hospital Empire section for details

- **Medical, Dental, Optical, Prescription Drug and Death Claims Appeals**

All medical, dental, optical, prescription drug, and death claim appeals should be submitted in writing to the Board of Trustees at the Fund Office at:

Board of Trustees
 Bricklayers' Insurance and Welfare Fund
 66-05 Woodhaven Blvd.
 Rego Park, New York 11374

Appeals need to be submitted in writing to the appropriate organization within 180 days after you receive notice of denial.

REVIEW PROCESS

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

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

- The opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;
- The opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;
- A full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;
- The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or appropriate, the fiduciary or fiduciaries will:
 - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment; and
 - Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
 - The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.
- The Plan's Claim and Appeal Procedures are designed and intended to comply with the Department of Labor's Final Rule governing claims procedure for plans providing disability benefits. Accordingly, before an adverse benefit determination on review of a disability claim is issued, the Plan also shall provide, free of charge:

Any new or additional rationale or evidence considered, relied upon, or generated by the Plan, insurer or other person making the benefit determination (or at the direction of the plan, insurer, or such other person) in connection with the claims. Such rationale or evidence, if any, shall be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided and to give the claimant a reasonable opportunity to respond prior to such date.

- In addition to the Plan's other applicable claims and procedure rules, in the case of an adverse determination with respect to a disability claim, the Plan will provide:

An explanation of the basis for disagreeing with or not following the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant;

The views of medical or vocational experts whose advice was obtained on behalf of the Plan without regard to whether the advice was relied upon in making the benefit determination;

A disability determination, if any, made by the Social Security Administration presented to the Plan;

If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

Either the specific internal rules, guidelines, protocols, standards or other similar criteria relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;

A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claimant's claim for benefits; and

A notification to the claimant shall be provided, if applicable, in a culturally and linguistically appropriate manner; and the Plan will provide oral language services in the applicable non-English language to assist such claimants with filing claims and appeals.

Timing of Notice of Decision on Appeal

- **Hospital Claims:** See the Empire Hospital section for details on Empire's Appeals process. In general, Empire will handle appeals as follows:

Pre-Service Hospital Claim: Empire maintains a two level process for Appeals and Grievances. Empire will make the first level determination on the internal appeal or grievance of your initial Pre-Service Claim no later than fifteen (15) calendar days from the Plan's receipt of the appeal. You will be sent a written (or electronic, as applicable) notice of the appeal determination.

If you are dissatisfied with the outcome of the Level 1 Appeal or Grievance, a Level 2 Appeal or Grievance may be filed with Empire within sixty (60) business days from the receipt of the notice of the letter denying the Level 1 Appeal or Grievance. If the appeal is not submitted within that timeframe, Empire will not review it and the decision on the Level 1 appeal will stand. Appeals may be filed by telephone or in writing. A second level appeal determination will be made no later than fifteen (15) days from Empire's receipt of your request for a second level appeal review. No extension of the Plan's internal appeal review timeframes are permitted.

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

Concurrent Hospital Claims. You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to Empire. A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

Post-Service Hospital Claims. Empire will make the first level determination on the appeal of your initial Post-Service Claim no later than 30 calendar days from their receipt of the appeal request. Empire will provide a written notice of the determination within two (2) business days of reaching a decision. If Empire does not make a decision within sixty (60) calendar days of receiving all necessary information to review your appeal, Empire will approve the service. If the first level appeal determination results in an adverse benefit determination, you will have 60 calendar days from your receipt of a notice of adverse benefit determination to request a second level appeal review by writing to Empire. Empire will then make a second level determination no later than 30 calendar days from its receipt of the second level appeal. You will then be provided with a written (or electronic, as applicable) notification of the second-level appeal determination no later than 30 days after Empire receipt of your request for a second level appeal.

- **Post-Service Medical, Dental, Optical and Prescription Drug Claims:** Ordinarily, decisions on appeals involving Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. If such an extension is necessary, the Plan will provide you with a written notice of extension describing the special circumstances and date the appeal determination will be made. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be

notified of the decision as soon as possible, but no later than five (5) days after the decision has been reached.

- **Death Claims:** A written notice regarding a determination of your appeal will be sent to you within 60 days from the date your written request for an appeal is received by the Plan.

Notice of Decision on Review

A written (or electronic, as applicable) notice of the appeal determination must be provided to you that includes:

- The specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- Reference the specific Plan provision(s) on which the denial is based;
- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
- A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- If the denial was based on an internal rule, guideline, protocol or similar criterion a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request; and
- If the denial was based on a medical judgment (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge, upon request.

Each appeal shall be determined solely in the interest of the Plan and all the participants in a uniform and non-discriminatory manner and without any bias or conflict of interest.

Limitation on When a Lawsuit may be Started

You may not start a lawsuit to obtain benefits until after you have exhausted the Plan's mandatory appeal and claim procedures and a final decision has been reached on review or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than three (3) years after the end of the year in which medical or dental services were provided, or, if the claim is for disability benefits, more than three (3) years after the start of the disability.

IMPORTANT INFORMATION ABOUT THE PLAN

Definitions

Balance Billing: Balance billing refers to a bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowed Amount and what the provider actually charged (the billed charges). Amounts associated with balance billing **are not covered** by this Plan. Out-of-Network Health Care Providers commonly engage in balance billing. This means a participant may be billed for any balance that may be due in addition to the amount payable by the Plan. Generally, you can avoid balance billing by using In-Network providers. Typically, In-Network providers do not balance bill except in situations of third party liability claims. The *Summary of Plan Benefits* beginning on page 18 summarizes the In-Network and Out-of-Network benefits available to you, as well as any limitations or maximums that may apply to specific benefits.

COBRA: means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and refers to temporary continuation of health care coverage. See the COBRA chapter of this document for more information.

Legally Qualified Medical Doctor, Physician or Surgeon: as used in this booklet, means a legally qualified Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), recognized as a legally qualified physician when performing services in his specialty, which, if performed by an M.D. or a D.O. would be covered. In no event, however, will benefits be paid for treatment of corns, calluses, bunions (unless there is capsular or bone surgery), nails of the feet, weak feet, etc.

Benefit Program Period: beginning January 1, 1989, means the period beginning April 1 and ending March 31 of the following year.

See the Hospital Section for definitions of Hospital, Medical Necessity and Experimental.

Information About Plan Operation

The following information is provided to help you better understand how the Plan operates.

Plan Administration. The Board of Trustees is responsible for the administration of the Plan. The Board has appointed Jeremiah Sullivan to serve as official Plan Administrator.

Identification Numbers. The number assigned to the Board of Trustees by the Internal Revenue Service is 13-1575218. The number assigned to the Plan by the Board of Trustees is 501.

Agent for Service of Legal Process. The Trustees have designated the Plan Administrator as the Plan's agent for service of legal process. The address is shown at the end of this material. Service may also be made upon the Trustees, whose names and addresses are shown on the inside back cover of this booklet. Service may also be made upon the insurance company at its local office or at the addresses listed below under "Type of Administration and Funding", or upon the supervisory official of the Insurance Department in the state in which you reside.

Collective Bargaining Agreement. This booklet outlines the provisions of the Plan as referred to in the collective bargaining agreements between the participating employers and the BAC Local Union #1, NY for the International Union of Bricklayers and Allied Craftworkers. A list of participating employers and union locals is available upon written request to the Plan Administrator. A copy of the most recent agreement is available at the Fund Office.

Loss of Benefits. Other than failing to meet or continuing to meet the requirements for a benefit, there are no Plan provisions that would cause you to forfeit your benefits, provided timely claims are made. However, it is your responsibility to provide your current address to assure that you will receive your benefit checks, and to file your claims in a timely manner.

Plan Year. All records of the Plan are kept on a April 1 to March 31 calendar year basis.

Type of Plan. This Plan provides hospital, medical, surgical, dental, optical, prescription drug and death benefits.

Financing the Plan. Participating employers contribute to an irrevocable trust fund; there are no employee contributions. These assets (along with any investment earnings) are held in a Trust Fund for the purpose of providing benefits to covered participants and paying reasonable administrative expenses. The Board of Trustees is responsible for the investment funding policy of the Plan. The contributions are intended to qualify as tax-deductible under the Internal Revenue Code.

Plan Continuance. The Plan is intended to be maintained indefinitely and funded regularly each year. The Board of Trustees reserves the right to change or terminate the Plan.

Type of Administration and Funding

All benefits under the Plan are self-insured. Empire HealthChoice administers the hospital benefits. The Fund Office administers the medical, optical and special Benefits. Save Rx administers the Prescription drug benefits. SIDS administers the dental benefits. MagnaCare administers the PPO. Vision Services provides the optical voucher. The addresses and telephone numbers of the entities that insure and/or administer Fund benefits are shown below:

Empire HealthChoice Assurance, Inc.
11 West 42nd Street
New York, NY 10036
(800) 553-9603

SavRx
224 North Park Avenue
Fremont, Nebraska 68025
(800) 228-3108

Self-Insured Dental Services
Dept. 75
PO Box 9005
Lynbrook, NY 11563-9005
(516) 396-5500 or (718) 204-7172

MagnaCare
1600 Stewart Ave, Suite 200
Westbury, NY 11590
(800) 235-7330

Vision Services

General Vision Services (GVS)

520 Eighth Avenue
Ninth Floor
New York, NY 10018
(212) 594-2580

Vision Screening

1919 Middle Country Road
Centereach, NY 11720
P: (718) 895-4504
P: (631) 467-4515
F: (631) 467-7786

Right to Amend or Terminate the Plan

The Board of Trustees intends to continue the benefit programs described in this SPD indefinitely. Nevertheless, it reserves the right, subject to the provisions of any pertinent collective bargaining agreement, to terminate or amend any or all of the Plan's benefit programs in whole or in part at any time in the future. If any questions concerning eligibility for benefits arise, the Trustees have sole and exclusive authority to resolve the issue. The Trustees' decisions are final and binding. The Plan may be terminated by the Board of Trustees when there is no longer in effect an agreement between an employer and the Union requiring contributions to the Plan. Upon termination of the Plan's benefit programs, the Board of Trustees will apply the monies of the Plan to provide benefits or otherwise to carry out the purposes of the Plan in an equitable manner until all of the remaining assets of the Fund have been disbursed.

Under no circumstances will any Plan benefits become vested or non-forfeitable with respect to active or retired employees or their beneficiaries or dependents.

Plan benefits and qualification rules if you are active, retired or disabled:

- May be changed or discontinued by the Board of Trustees at any time, in their sole discretion;
- Are subject to the rules and regulations adopted by the Board of Trustees;
- Are subject to the Trust Agreement that establishes and governs the Fund's operations; and

- Are subject to the provisions of the group insurance policies, if any, purchased by the Trustees.

No Liability for Practice of Medicine or Dentistry

While the Plan provides participants and covered dependents with health benefits, the Plan, the Board of Trustees, or any of their designees are **not** engaged in the practice of medicine or dentistry, 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, the Board of Trustees, 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.

Information You or Your Dependent Must Furnish to the Plan

In addition to information you must furnish in support of any claim for plan benefits under this Plan, it is your responsibility to be aware of the rules of the Plan. The Fund Office offers many options for maintaining communication with you regarding critical matters that can affect your benefits, such as our web-site, regular mail, and e-mail and text messaging. But none of those options work if we do not have your most up-to-date contact information. Please remember that when your contact information changes in any way, you should inform the Fund Office immediately. In this regard, it is also your responsibility to notify the Fund Office immediately if any of the following occurs:

- Change of name
- Change of address. (Advise the Fund Office promptly so its records will be up-to-date to communicate with you about any matters concerning your coverage.)
- The marriage, divorce, legal separation, or death of you or any covered spouse or dependent child
- Any information regarding the status of your dependent child, including, but not limited to:
 - Your dependent child's reaching the Plan's limiting age
 - The existence of any physical or mental handicap
 - The marriage of your dependent child
 - Medicare enrollment or dis-enrollment
 - Social Security disability benefits award or termination
 - The existence of other medical or dental coverage

In addition, your spouse or other family member must notify the Fund Office in the event of your death.

As a reminder, you need to inform the Fund Office separately even if you have updated your information with the Union, since the Plan is a separate legal entity. If changing all of your contact

information is too burdensome because of many changes or temporary situations, please at least update the communication channel that is most likely to be used by you.

Overpayments

If a payment to a participant or dependent or assigned to a provider is determined to be paid in error or otherwise be an overpayment, the Board of Trustees or the Plan may commence legal action to recover the overpayment and offset future claim payments to recover the amount overpaid.

Important Notice Regarding Annual Dollar Limits

In accordance with applicable law, the Plan does not impose lifetime or annual dollar limits on “essential health benefits” as such term is defined under Section 1302(b) of the Affordable Care Act. A determination as to whether a benefit constitutes an “essential health benefit” will be based on a good faith interpretation by the Plan Administrator of the guidance available as of the date on which the determination is made. Additional information regarding the specific application of these rules may be furnished in a future communication as regulatory and other guidance governing the law is issued by the government.

Not a Contract of Employment

This SPD is not a contract of employment (including without limitation Covered Employment) – it neither guarantees employment or continued employment with your Contributing Employer or any Contributing Employer, nor diminishes in any way the right of Contributing Employers to terminate the employment of any employee.

Facility of Payment

Every person receiving or claiming benefits through the Plan will generally be presumed to be mentally and physically competent and of age. However, if the Plan Administrator (or its designee) determines that a person entitled to receive benefits hereunder is a minor, or is physically or mentally incompetent to receive the payment or to give a valid release for benefits, the Plan may issue payments to the person’s legally appointed guardian, committee or representative (upon proof of the appointment) or, if none, to another person or entity that the Trustees determine appropriate in their sole and absolute discretion. Any payment made in accordance with this provision will discharge entirely the obligation of the Plan.

Plan Administrator's Authority

The Board of Trustees, as the Plan Administrator of the Plan's benefit programs, (or its duly authorized designee(s)) has full discretion and exclusive authority to make the final decision regarding all areas of plan interpretation and administration, and to decide all matters arising in connection with the operation and administration of the Plan or Trust. Without limiting the generality of the foregoing, the Board (or its authorized designee(s)) shall have the sole and absolute discretionary authority to do the following:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with the terms of the Plan;
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this book, the Trust Agreement or other Plan documents;
- Process and approve or deny benefit claims; and/or
- Determine the standard of proof required in any case.

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. The decision of the Board of Trustees is final and binding on all participants, beneficiaries, and any other individuals dealing with or claiming benefits under the Plan. The Board of Trustees may delegate any other such duties or powers as it deems necessary to carry out the administration of the Plan. Accordingly, no participating employer, employer organization or labor organization, nor any individual employed thereby, has authority to answer questions on behalf of the Plan. Please refer all questions to the Board of Trustees.

Severability

If any provision of this SPD is held invalid, unenforceable or inconsistent with any law, regulation or requirement, its invalidity, unenforceability or inconsistency will not affect any other provision of the SPD, and the SPD shall be construed and enforced as if such provision were not a part of the SPD.

Construction of Terms

Words of gender shall include persons and entities of any gender, the plural shall include the singular and the singular shall include the plural. Section headings exist for reference purposes only and shall not be construed as part of the SPD.

Applicable Law

The Plan shall be construed and enforced according to the laws of the State of New York to the extent not preempted by ERISA and any other applicable federal law.

No Vested Interest

Except for the right to receive any benefit payable under the Fund in regard to a previously incurred claim, no person shall have any right, title, or interest in or to the assets of any Contributing Employer because of the Plan.

Assignment of Plan Benefits

Your right to receive any benefit or reimbursement under the Fund is not alienable by you by assignment or any other method of transfer and is not be subject to being taken by your creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law. You cannot pledge benefits owed to you for the purpose of obtaining a loan. Accordingly, benefits are not subject to any creditor's claim or to legal process by any creditor of any covered individual, except under a QMCSO and to the extent as may be required by law. For more information on QMCSO, please refer to page 6.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a participant in the 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:

Receive Information About Your Plan and Benefits

- ☞ Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Pension and Welfare Benefits Administration.
- ☞ Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator's office may make a reasonable charge for the copies.
- ☞ Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- ☞ Continue health care coverage for yourself, spouse or dependent children if there is loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- ☞ Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining welfare Fund benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, 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 D.C, 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

HIPAA: NOTICE OF PRIVACY PRACTICES (“NOPP”)

HIPAA also gives you certain rights with respect to your health information, and it also imposes certain obligations on the Plan as a group health plan. The following describes how medical information about you may be used and disclosed and how you can get access to this information. This information also applies to your spouse and other qualified dependents. So, please share it with them.

The Plan is committed to maintaining the confidentiality of your private information and has drafted this NOPP in accordance with the HIPAA Privacy Rule, contained in the Code of Federal Regulations at 45 C.F.R. Parts 160 and 164. Terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule, as amended by Health Information Technology For Economic and Clinical Health Act (HITECH).

This NOPP describes our efforts to safeguard your protected health information (PHI) from impermissible use or disclosure. As a group health plan, the Plan is a covered entity under HIPAA and, as a result, is required under such law to provide you with notice of its legal duties and privacy practices with respect to PHI. PHI includes any individually identifiable information that relates to your physical or mental health, the health care that you have received or benefit payments for your health care, including your name, address, date of birth and Social Security number. These rules do not apply to any disability, death or other non-health benefits provided under the Plan.

The Plan is legally required to maintain the privacy of your PHI. The primary purpose of this NOPP is to describe the legally permitted uses and disclosures of PHI, even though some may not apply to this Fund in practice. This NOPP also describes your right to access and control your PHI. Although the Plan is required to abide by the terms of this NOPP, it reserves the right to change the terms of this NOPP and to make new provisions regarding your PHI that it maintains, as permitted or required by law. If the Plan makes a material change to this Notice, it will provide you with a copy of the revised Notice of Privacy Practices. Additionally, you may contact the Plan directly at any time to obtain a copy of the most recent NOPP. This NOPP is effective as of April 1, 2017.

Your Protected Health Information

Protected Health Information (PHI) Defined.

The term “Protected Health Information” (PHI) includes all health information, including demographic information, collected from you or created or received by the Plan, a health care provider, a health care clearinghouse, a health plan, or your employer, from which it is possible to individually identify you and that relates to your (i) past, present or future physical or mental health or condition, (ii) the provision of health care to you, or (iii) the past, present, or future payment for the provision of health care to you. Individually identifiable information includes your name, address, date of birth, employee ID number, and Social Security number that is linked to the above-referenced matters concerning your health care, regardless of whether such information is transmitted orally, in writing, electronically or in any other form.

How the Plan May Use and Disclose Your Protected Health Information.

Generally speaking, the Plan has amended its plan documents to protect your PHI as required by federal law. Under the law, however, the Plan may disclose your PHI without your consent in the following cases:

- Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.
- As required by an agency of the government. The Secretary of the United States Department of Health and Human Services (HHS) may require the disclosure of your PHI to investigate or determine the Plan's compliance with privacy regulations.

In addition, under the law, the Plan may also use or disclose your PHI under other certain circumstances without your permission. The following categories (as well as those described in "*Other Permitted Uses and Disclosures of Your PHI for Which Consent, Authorization or Opportunity to Object is Not Required*") describe the different ways that the Plan may use or disclose your PHI without your consent. For each category of uses or disclosures, this Notice will explain the scope of the unauthorized disclosure and provide some examples. Please note that not every use or disclosure in a category will be listed. Nevertheless, all of the ways that the Plan will be permitted to use or disclose PHI will fall into one of these categories.

For Treatment, Payment and Health Care Operations.

Treatment. Although the Plan does not provide treatment, it may use or disclose your PHI to support the provision, coordination or management of your health care treatment. For this compliance purpose, "treatment" also includes, but is not limited to, consultations and referrals between one or more providers. For example, in the process of arranging for durable medical equipment services ordered by your attending physician with a contracted service provider, the Plan may disclose your name, address, telephone number and diagnosis to the service provider's intake coordinator.

Payment. The Plan may use or disclose your PHI with regard to its payment activities. "Payment" includes, but is not limited to, actions to make eligibility determinations, coverage determinations and payment (including resolving payment disputes, responding to payment inquiries, subrogating or obtaining reimbursement, conducting medical necessity and appropriateness of care claim reviews, utilization review and precertification). For example, the Plan may advise a physician's office whether you are eligible for coverage and the benefit amount payable by the Plan. Also, explanation of benefit statements are mailed to the address the Plan has on record for a participant.

Health Care Operations. The Plan may use or disclose your PHI as part of its general administrative or business functions in order for it to function as a health plan. These functions include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, case management, disease management, activities relating to the creation and renewal of insurance and benefit administration contracts, legal services, auditing services, and general administrative activities, including data and information systems management. For example, the Plan may use information from your claims to refer you

to case management, determine benefit costs, or for auditing the accuracy of claims processing functions.

Disclosure To Third Parties. The Plan may contract with individuals and entities known as Business Associates to perform various functions on its behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use and/or disclosure your PHI, but only after they agree in writing with the Plan to implement appropriate safeguards regarding your PHI. For example, the Plan may contract with a service provider to perform the administrative functions necessary to pay your medical claims.

Reminders. The Plan may use your PHI to provide you with reminders. For example, the Plan may use your child's date of birth to remind you that you may purchase COBRA continuation coverage for your child who would otherwise lose coverage under the Plan due to age, or to remind you to make an appointment with your physician.

Treatment Alternatives. The Plan may use your PHI to inform you about treatment alternatives.

Health-Related Benefits and Services. The Plan may use or disclose your PHI to inform you about other health-related benefits and services that may be of interest to you.

Disclosure to the Plan Sponsor. The Plan may disclose your PHI to its Board of Trustees ("Board" or "Trustees"), which serves as the Plan Sponsor for the Plan, (or its designated committee) for purposes related to the Plan's payment and health care operations, including in connection with appeals that you file following a denial of a benefit claim. In addition, the Fund Office may receive your PHI if you request assistance in filing or perfecting your claim for benefits under the Plan. The Trustees may also receive your PHI if necessary for them to fulfill their fiduciary duties with respect to the Plan. When disclosing PHI to the Board, the Plan will make reasonable efforts not to disclose more than the minimum necessary amount of PHI to achieve the particular purpose of the disclosure. Unless authorized by you in writing, your PHI: (1) may not be disclosed by the Plan other than as permitted in this Notice or as required by law, or (2) will not be used with respect to any employment-related actions or decisions, or (3) with respect to any other benefit plan sponsored by or maintained by the Board.

In addition, the Plan may disclose "summary PHI" to the Board for obtaining premium bids or modifying, amending or terminating the Plan. Summary PHI summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor (such as the Board of Trustees) has provided health benefits under a group health plan. Identifying information will be deleted from summary PHI, in accordance with federal privacy rules.

When the Disclosure of Your PHI Requires Your Written Authorization.

The Plan must generally obtain your written authorization before (each of these includes defined exceptions under which the Plan may use or disclose your PHI for these purposes without your authorization):

- Using or disclosing psychotherapy notes about you from your psychotherapist.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan is not likely to have access to or maintain these types of notes.

- Using or disclosing your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed.
- Receiving direct or indirect remuneration (payment or other benefit) in exchange for receipt of your PHI.
- Using and disclosing your PHI for any use or disclosure not described within this Notice. At any time, you may revoke your authorization in writing except where the Plan has taken action in reliance on your authorization.

Other Uses and Disclosures for Which Consent, Authorization or Opportunity to Object are Not Required.

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your PHI without your specific consent, authorization or request. For each category of uses or disclosures, this Notice will explain the scope of the unauthorized disclosure and provide some examples. Please note that not every use or disclosure in a category will be listed. Nevertheless, all of the ways that the Plan will be permitted to use or disclose PHI will fall into one of these categories.

- (1) When required by law.
- (2) When permitted for purposes of public health activities. This includes reporting product defects, permitting product recalls and conducting post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- (3) When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under law when the parents or other representatives may not be given access to the minor's PHI.
- (4) The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil,

administrative or criminal investigations and audits; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud); or for the government to monitor the health care system, government programs and compliance with civil rights laws.

- (5) The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request or other lawful process by someone involved in such legal dispute, provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
- (6) When required for law enforcement health purposes, including the reporting of certain types of wounds. Also when required for law enforcement emergency purposes if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Plan in its best judgment determines that disclosure is in the best interest of the individual. Law enforcement emergency purposes include identifying or locating a suspect, fugitive, material witness or missing person, and disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.
- (7) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- (8) The Plan may use or disclose PHI for research, subject to certain conditions and limitations.
- (9) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- (10) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

- (11) The Plan is permitted to disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has established protocols to ensure the privacy of your PHI, or the research involves a limited data set which includes no unique identifiers (information such as name, address, social security number, etc., that can identify you).
- (12) When the appropriate conditions apply, the Plan may use or disclose PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by military command authorities; or (2) to a foreign military authority if you are a member of that foreign military service. The Plan may also disclose your PHI to authorized federal officials conducting national security and intelligence activities.
- (13) If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may disclose your PHI to the institution or official if the PHI is necessary for the institution to provide you with health care; to protect the health and safety of you or others; or for the security of the correctional institution.
- (14) If you are an organ donor, the Plan may release your PHI after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Any other Fund uses and disclosures not described above will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization. If you provide us with written authorization to use or disclose your PHI for purposes other than those set forth in this Notice, you may revoke that authorization in writing at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization. However, the Plan is unable to take back any disclosures that the Plan has already made with your authorization, and the Plan is required to retain records of the care that the Plan provided to you.

Disclosures to Others Involved in Your Health Care.

Disclosure of your PHI to family members, other relatives and your close personal friends without your written consent or authorization is allowed if the information is directly relevant to the family or friend's involvement with your care or payment for that care and you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

If you are not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of your incapacity or emergency circumstance, the Plan may nevertheless make a disclosure of your PHI to family members, other relatives and your close personal friends if the Plan concludes, based on professional judgment and its experience with common practice, that the disclosure is in your best interest.

You can ensure that no disclosures will be made by the Plan under this section to your family members, other relatives and close personal friends by filing a written restriction with the Plan as described below.

YOUR INDIVIDUAL PRIVACY RIGHTS

Breach Notification.

If a breach of your unsecured PHI occurs, the Plan will notify you.

Uses and Disclosures Requiring Your Written Authorization.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization, subject to your right to revoke such authorization. Your authorization must be in writing and contain certain elements to be considered a valid authorization. You may call or write the Fund Office to request an authorization form be sent to you.

Personal Representatives.

You may exercise your rights through a personal representative. An individual purporting to act as your personal representative will be required to produce evidence of authority to act on your behalf before being provided access to your PHI or being allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a Notary public;
- A court order of appointment of the person as conservator or guardian;
- An Appointment of Personal Representative form that is completed and signed by you; or
- An individual who is the parent of a minor child.

Notwithstanding the foregoing, the Plan retains the right to deny access to your PHI to a personal representative in certain abuse, neglect or endangerment situations where the Plan concludes it is in your best interest to deny access. This also applies to personal representatives of minors.

Rights of Individuals.

Right to Request Restrictions on PHI Uses and Disclosures.

You may request, in writing, that the Plan restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations or to restrict uses and disclosures to family

members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to a requested restriction. If the Plan does agree to the request, the Plan will not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment or the Plan terminates the restriction with or without your agreement. Your request must include the PHI you wish to limit, whether you want to limit the Plan's use, disclosure, or both, and (if applicable), to whom you want the limitations to apply (for example, disclosures to your spouse). You have the right to request that the Plan not disclose PHI to a health plan for "payment or health care operations," as defined by HIPAA, if the provider has already been paid in full by the individual for the health care services.

The Plan will accommodate reasonable written requests for communications of PHI by alternative means or at alternative locations (e.g., send your Explanation of Benefits to your office, instead of at home). You or your personal representative will be required to complete the Plan's model form to request restrictions on uses and disclosures of your PHI.

Make such requests to the Plan's Privacy Officer who may be contacted at (718) 459-5800.

Right to Inspect and Copy PHI.

You have the right to inspect and obtain a copy of your PHI (in hardcopy or electronic form) that is contained in a "designated record set" – medical records and other records maintained and used in making enrollment, payment, claims adjudication, case management and other decisions about you – for as long as the Plan maintains the PHI. You may request your hardcopy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You also may request a summary of your PHI. Requests for access to your PHI must be made in writing. Requested information will be provided within 30 days of receipt of your request. A single 30-day extension is allowed if the Plan provides you with a written statement of the reasons for the delay and the expected date by which the Plan will provide the information.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set.

You may be charged a reasonable, cost-based fee for copying the PHI, or preparing a summary of you PHI. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. Requests for access to PHI should be made to the Plan's Privacy Officer who may be contacted at (718) 459-5800.

If access is denied, you or your personal representative will be provided with a written denial explaining the basis for the denial. Such notice will advise you that you may request in writing to have the denial reviewed by a licensed health care professional designated by the Plan to act as a reviewing official and who did not participate in the original decision to deny. Such denial will also describe how you may complain to the Plan or the Secretary of the Department of Health and Human Services pursuant to the complaint procedures described herein.

Right to Amend PHI.

You have the right to submit a written request to amend your PHI contained in a “designated record set” for as long as the Plan maintains the PHI. The Plan will act on the request within 60 days of receipt. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline.

The Plan, however, may deny your request for an amendment if it is not in writing or does not include a valid reason to support the request. In addition, the Plan may deny your request if you ask the Plan to amend information that did not originate with the Plan; is not contained in the records maintained by the Plan; is not part of the information that you would legally be permitted to inspect and copy; or is accurate and complete.

If your request is denied in whole or in part, you or your personal representative will be provided with a written denial explaining the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Your request to amend your PHI must be made in writing to the Plan’s Privacy Officer who may be contacted at (718) 459-5800.

You or your personal representative will be required to complete the Plan’s model form to request amendment of your PHI.

Right to Receive an Accounting of PHI Disclosures.

The Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six (6) years prior to the date of your written request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; (4) based on your written authorization; (5) to friends or family in your presence or because of an emergency; (6) for national security purposes; and (7) incidental to otherwise permissible disclosures. Any request for an accounting must be submitted in writing. An accounting will be provided within 60 days of receipt of your request. Your first request for an accounting in a 12-month period will be responded to without charge. You may be charged a reasonable, cost-based fee for each additional request for an accounting within such 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Submission of Requests.

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. The requests described above should be submitted in writing to the Fund Office at the address at the end of this Notice.

Right to Receive Paper Copy of This Notice Upon Request.

You have the right to receive a paper copy of this Notice, contact the Plan’s Privacy Officer who may be contacted at (718) 459-5800.

This right applies even if you have agreed to receive the Notice electronically.

THE PLAN'S DUTIES

Maintaining Your Privacy.

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices. In addition, the Plan may not (and does not) use your genetic information that is PHI for underwriting purposes.

The Plan reserves the right to change its privacy practices and to apply changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to you and to all past and present participants and beneficiaries for whom the Plan still maintains PHI.

If material changes are made to this Notice, it will be posted on the Plan's website promptly by the effective date of the material change, or the Plan will send a hard copy of the revised notice in its next annual mailing. Material changes are changes to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this Notice.

Minimum Necessary Standard.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts to limit the use or disclosure of PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to you or pursuant to an authorization initiated by you;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law; and
- Uses or disclosures required for the Plan's compliance with the HIPAA privacy regulations.

De-Identified Information.

This Notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR HHS

Questions/Complaints.

If you believe that your privacy rights have been violated or have any questions regarding this Notice or the subjects addressed in it, you may file a complaint with or submit your questions to the Plan's Privacy Officer who may be contacted at (718) 459-5800.

You may also file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. Filing instructions are available at: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html> All complaints must be submitted in writing.

The Plan will not penalize or retaliate against you for filing a complaint.

HIPAA: Certificate of Creditable Coverage

When your health coverage or COBRA Continuation Coverage by the Plan ends, you and/or your covered dependents were entitled by law to, and will automatically be provided with, a "Certificate of Creditable Coverage" (HIPAA Certificate), that indicates the period of time you and/or they were covered by the Plan. Under prior law, if, within sixty-three (63) days after your health benefit coverage under the Plan ends, you and/or your covered dependents become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered dependents a health insurance policy, this HIPAA Certificate may be necessary to reduce or eliminate any exclusion for pre-existing conditions that may apply to you and/or your covered dependents in that group health plan or health insurance policy. The certificate indicated the period of time you and/or they were covered by the Plan, and certain additional information that is required by law. However, effective as of December 31, 2014, HIPAA Certificates of Creditable Coverage are no longer required to be provided by the Plan pursuant to the applicable under the Affordable Care Act.

Please note, however, that this Plan does not contain any preexisting condition exclusions or limitations in accordance with the applicable requirements under the Affordable Care Act.